

**Novel Coronavirus (Covid-19)**

**Pre-op Screening Form**

**TEMPERATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Protocol:** All patients will receive a pre-op screening phone call for exposure risk to Covid-19 and symptoms of respiratory illness.

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| --- | --- | --- |
| **Questions** | **Yes** | **No** |
| 1. Have you, your companion / family member coming to the facility with you on the day of surgery, been in close physical contact with a person laboratory-confirmed with Covid-19 in the LAST 7 DAYS? |  |  |
| 1. Have you, your companion to the surgery center / a family member you have been in direct contact with, been in close physical contact with a person who is currently being quarantined for Covid-19 exposure IN THE LAST 7 DAYS? |  |  |
| 1. Have you or your companion to the surgery center traveled in the last 7 days? |  |  |
| 1. Have you or your companion on the day of the surgery/ a family member you have been in direct contact with, had any of the following symptoms in the past 3 days that are not caused by another condition? |  |  |
| * Fever (Temperature of =or> 100.4) or chills |  |  |
| * Sore throat/ Cough |  |  |
| * Shortness of breath |  |  |
| * Loss of smell or taste |  |  |
| * Muscle pain |  |  |
| * Headache |  |  |
| 1. Within the past 7 days, has a public health / medical professional advised you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection? |  |  |

**If the answer is NO to all the above, the patient may come in on the scheduled surgery date.**

**If the answer is YES to any of the above, instruct the patient to contact their surgeon to reschedule their surgery.**

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| 1. Have you been tested for Covid-19 in the past 5 days?   Date of test/facility: |  |  |
| 1. Was the test negative? |  |  |
| 1. If your test is negative, please self-isolate at home until you have your surgery to avoid possible exposure to Covid-19. |  |  |

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If your Covid-19 test is POSITIVE, you will be instructed to contact your surgeon to reschedule your procedure.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient signature Date**