



COVID-19 Screening Tool for Nursing Homes

Updated October 23, 2020

Date: _____ Name: _____

Reason for entering facility: _____

Please let us know if you or someone in your home has had any of the following:

Symptom Screening Questions	Yes	No
Cough		
Diarrhea		
Fatigue		
Fever (temperature of 100° F or higher) or chills		
Headache		
Muscle or body aches		
Nausea or vomiting		
Recent loss of taste or smell		
Runny or stuffy nose		
Shortness of breath or difficulty breathing		
Sore throat		

*If the answer to **any** of the symptom screening questions is **yes**, the person should be excluded from the facility and contact their healthcare provider for evaluation.*

Please list the names of healthcare facilities you have visited or worked in during the last 14 days:

Call the Rhode Island Department of Health at 401-222-2577 for COVID-19 testing of staff who are ill.

Quarantine Screening Questions	Yes	No
Has anyone in your household been diagnosed with COVID-19?		
Have you been told to quarantine by any public health authority? If so, when does/did your 14-day quarantine end?		
Have you been in close contact (less than six feet for 10-15 minutes) with someone who has tested positive for COVID-19, without wearing appropriate personal protective equipment (PPE)?		
Have you traveled anywhere outside of the United States, on a cruise, or within the United States by commercial airlines?		
Have you traveled to Rhode Island from any "hotspot" state by any mode of transportation?		

*If the answer to **any** quarantine screening question is **yes**, the person should be excluded from the facility and should quarantine until **14 days** have passed since they were exposed, traveled back to Rhode Island, or started quarantine. (Note: Asymptomatic staff members may continue to work while wearing a mask if their absence would cause a **staffing hardship**.)*

-----OFFICIAL USE ONLY-----

Temperature: _____ Staff signature: _____

Cleared to enter facility? _____ Yes _____ No