# NOVEL CORONAVIRUS (COVID-19) SCREENING FORM

**For Admission to NYS OMH Adult, Forensic, and Child Psychiatric Center's Inpatient Services**

Please fill out the screening form below and sign at the bottom once completed. **PLEASE** e-mail a copy of this PDF to the PC through the Health Commerce System as you do with other clinical and administrative referral documentation

**Patient Name:**

**Patient's Date of Birth:** _____

1. **Has the patient traveled internationally to a CDC-designated Level 2 or Level 3 country within the last 14 days?**

   ☐ Yes ☐ No

   If **yes,** please indicate where the patient traveled, whether the patient has been tested and results (i.e., pending, COVID negative), and other pertinent information:

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2. **Has the patient been in a domestic area of focus where COVID-19 prevalence is high within the last 14 days? (e.g., New Rochelle, NY was designated for high focus on 3/10/20)**

☐ Yes ☐ No

If **yes,** please indicate where the patient traveled, whether the patient has been tested and results (i.e., pending, COVID negative), and other pertinent information:

3. **Has the patient had direct contact with a person confirmed to be positive for COVID-19?**

☐ Yes ☐ No

If **yes**, please indicate what, if any, testing has been done to date:

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**4. Is the patient experiencing any of the following symptoms?**

**Fever** ☐ Yes ☐ No

If **yes**, please detail the last 36-hours of temperature recordings and current management

**Sore throat** ☐ Yes ☐ No

If **yes**, please detail symptom history and management:

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**Cough** ☐ Yes ☐ No

If **yes**, please detail symptom history and management:

**Shortness of breath?** ☐ Yes ☐ No

If **yes**, please detail symptom history and management:

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If **yes**, does the patient have comorbid pulmonary conditions? If so, please detail:

Name of the Referring Facility: _____

Name of the Referring Physician/Nurse Practitioner: _____

_____

Contact Number of Referring Physician / Nurse Practitioner: _____

Referring Physician/Nurse Practitioner Signature: _____

Date of Completion: _____

Time of Completion (Please use military time, e.g., 14:06): _____

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