TODAY'S DATE: _____

BMC COVID-19 SCREENING

PLEASE ASK EACH PATIENT THESE QUESTIONS:	Note what applies:	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**

Did the patient answer **NO** to **ALL QUESTIONS**?	Access to BMC APPROVED.
Did the patient answer **YES** to **ANY QUESTION**?	Access to BMC facilities **NOT APPROVED**. Please refer this case to the **doctor** for further instructions!