**Infection Control Screening**

Staff Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Call Out: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Call:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the staff person been told by a medical person they should be quarantined? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the staff person you able to work from home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the below signs or symptoms? (Please **check** all that apply)

**\_\_ Fever Temp: \_\_\_\_\_\_\_F \_\_ Cough \_\_ Difficulty Breathing/Shortness of Breath**

\_\_ Chest Congestion \_\_ Nasal/Sinus Congestion \_\_ Runny Nose

\_\_ Poor Appetite \_\_ Dizziness \_\_ Body Aches

\_\_ Chills \_\_ Headache \_\_ Nausea/Vomiting

\_\_ Stomach Cramps/Abdominal Pain \_\_\_\_Other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Date Symptoms Began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Did you work or attend any public areas since symptoms began? (if so, describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Who have you been in contact with since symptoms began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you contacted or seen a doctor? **Yes No**
* If you received a diagnosis, what was it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you been hospitalized for this illness? **Yes No**
* Have you traveled outside the country within the past 14 days? **Yes No**
* If so, what country did you travel to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What date did you arrive home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you had close contact with anyone with a laboratory confirmed COVID-19 or Patient Under Investigation (PIU) for COVID-19? **Yes No** Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete the information and procedure on the reverse of this form.**

**Interviewer Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unit/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read the information below to the caller:**

All forms are reviewed by The Office of the Medical Director.

Please call your medical provider if you have any symptoms of illness, but especially if you have fever, cough, shortness of breath, abdominal cramps, or sore throat, or if you have recently traveled from China, Iran, Italy, Japan, South Korea or other areas with widespread/ongoing community spread of COVID-19. The most current list of countries with travel restrictions can be found at cdc.gov.

Please follow your medical provider’s advice. If they feel that you should be tested for COVID-19, you need to call DPH to notify them you are being tested and follow any additional recommendations. Please call **1-866-408-1899.**

Be advised that a call-out due to illness may require you to remain out of work for a period of two weeks or more. You will need to be cleared by The Office of the Medical Director before returning to work. At that time, you may need to provide the enclosed doctor’s note completed by your treating physician. If you feel you are able to return to work sooner, you may provide the aforementioned doctor’s note sooner. At that time, your request will be evaluated by The Office of the Medical Director.

Interviewer, please initial here after reading the above to the staff member: \_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\*\*Recording interviewer, please scan and email this form to Mary.Wise@delaware.gov and April.Johnson@delaware.gov