Deborah Heart and Lung Center

Limited Visitation Screening Tool during COVID-19 Pandemic

Date: _____ Time: _____

Visitor Demographic Information

Name: _____ Date of Birth: _____

Address:

_____

_____

_____

Phone Number: _____ home cell other:_____

Patient to be visited: _____ Room # _____

Symptom Screen

Have you had any of the following symptoms in the past two weeks? Mark answer with X

Symptom:	Yes	No		Symptom:	Yes	No
Fever				Chills, muscle pain		
Cough				Vomiting		
Shortness of Breath				Diarrhea		
Loss of taste or smell				Sore throat		

If yes to any of the symptoms listed above, no visitation allowed.

Temperature Screen

Temperature: _____

If temperature is greater than 100.0 degrees F, no visitation allowed.

COVID Screen

Questions:	Yes	No
Have you been in close contact with anyone who has Covid or has been tested for Covid because they think they may have it?		
Do you believe you have Covid or have you been tested for Covid?		

If yes to either of the questions listed above, no visitation allowed.

Travel Screen

Travel History	Yes	No
Have you traveled outside of NJ in the last two weeks?		
Have you visited any of the states listed on the travel advisory or any international travel in the last two weeks?		

If yes to any travel above, no visitation allowed.

Visitor attests that the information provided on this form is accurate and true to the best of their knowledge, and that failure to truthfully answer any of these questions could result in the further spread of the Coronavirus not only to their loved one they are visiting, but also to other patients, visitors, and Hospital staff who are heroically caring for patients every day.

Print Name of Visitor: _____

Signature of Visitor: _____ Date: _____ Time: _____

Screening Results confirmed by: _____

Visitor permitted to visit: _____ Yes _____ No