HILL ALCOHOL AND DRUG TREATMENT
COVID- 19 Screening for Patients and Visitors

To protect everyone, we are asking **all** patients and guests to complete the following questionnaire.

Name: _____ Date: _____

Have you, in the past 21 days:

- Had any of the following symptoms: **Temperature of 99.6 or above, or possible fever symptoms like alternating chills and sweating**, cough, sore throat trouble breathing, shortness of breath or severe wheezing? YES / NO

- Traveled outside the US? YES / NO
  If yes, where and the length of time:
  _____

- Traveled within the US to a potential "Hot Spot"? YES / NO
  If yes, where and the length of time:
  _____

- Been in close contact with someone diagnosed with coronavirus (COVID- 19)? YES / NO

- Been in close contact with anyone who has traveled outside the US or traveled within the US to a potential "Hot Spot"? YES / NO

Reviewed by (Staff): _____