APPENDIX A
COVID-19 PATIENT TRIAGE QUESTIONS

PATIENT NAME:	DOB:
	AGE:
PHONE NUMBER:	

QUESTIONS:	Pre-Screen Date:		Arrival Date:	
1. Have you tested positive for COVID-19 in the past 2 weeks?	☐YES	☐NO	☐YES	☐NO
2. Do you live with or care for someone who has COVID-19?	☐YES	☐NO	☐YES	☐NO
3. Have you had a fever greater than 100.4°F in the past 48 hours?	☐YES	☐NO	☐YES	☐NO
4. Do you have a sore throat?	☐YES	☐NO	☐YES	☐NO
5. Do you have a cough?	☐YES	☐NO	☐YES	☐NO
6. Are you experiencing any shortness of breath or difficulty breathing?	☐YES	☐NO	☐YES	☐NO
7. Have you lost your sense of taste/smell in the past 48 hours?	☐YES	☐NO	☐YES	☐NO
8. Have you experienced vomiting or loose stools recently?	☐YES	☐NO	☐YES	☐NO
9. Do you have a headache, body, or muscle aches?	☐YES	☐NO	☐YES	☐NO
10. Have you traveled outside of your county in the past 14 days? If yes, where?	☐YES	☐NO	☐YES	☐NO
11. Do you have heart, kidney, or lung disease?	☐YES	☐NO	☐YES	☐NO
12. Do you have any other condition that might increase your risk of infection?	☐YES	☐NO	☐YES	☐NO

Any positive responses need to be reviewed by the patient's dentist.

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