

Pre-Screening Patients for Pulmonary Testing
Assessing for low or high-risk patient and low or high-risk community.

Patient name _____

Type of testing requested _____ Dx _____

Provider requesting testing _____

Review of EMR: Date/Time of access _____

State of residence _____ City _____ County _____

Previous result found for COVID-19 test _____ Date _____

Previous PFT testing? Type _____ Date of testing: _____

Phone Screening: Are you self-monitoring? _____ Do you practice social distancing? _____

Living situation: Lives alone Lives with partner Family/ Multi-family Group/Nursing home

Are / were any family members ill recently? _____

Occupation: _____

Are you considered an "essential worker"? _____

Location of employment: City/State _____

Were any of your co-workers ill recently or dx /screen for COVID-19? _____

Travel history – past 6 weeks _____

Symptom Review

- Fever (100°F or higher)
- Chills
- Cough
- Sore throat
- Shortness of breath/chest tightness
- Loss of taste or smell
- Runny nose
- Nasal congestion
- Headache
- Severe fatigue/exhaustion
- Muscle pain

Assessment: **Low risk patient** **Low risk community** **High risk patient** **High risk community**