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**COVID-19 (Corona Virus) Screening Form**

For the safety of our patients and staff, Premier Plastic Surgery is temporarily limiting visitors and restricting patient care for those potentially infected with COVID-19 virus. All patients and visitors will be actively screened prior to entry. For patients recovering from surgery, we ask that you limit accompanying visitors to 1 per patient. Visitors will be asked to remain in their vehicle for the duration of the visit. Visitors will be permitted in the exam or waiting room only in special situations, when a visitor is essential for the well-being and care of the patient. No visitors who are ill, sick, frail, elderly or at-risk (i.e. immune compromised or serious chronic illness) will be permitted access. No children less than 18 years of age will be permitted. Please do not bring children to your visit. Any approved visitors will be screened at the facility entrance by a staff member and must comply with a temperature screening.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name), certify that I am willing to submit to a screening questionnaire and a body temperature reading today.

**Please circle the appropriate response to the following 4 questions.**

|  |  |  |
| --- | --- | --- |
| **In the last 14 days, have you had any signs or symptoms of a respiratory infection such as fever, cough, shortness of breath, or sore throat?** | **Yes** | **No** |
|  |  |  |
| **In the last 14 days, have you had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with respiratory illness?** | **Yes** | **No** |
|  |  |  |
| **Have you traveled internationally within the last 14 days to countries with sustained community transmission (outbreak) of COVID-19?** | **Yes** | **No** |
|  |  |  |
| **Do you reside within a community where community-based spread of COVID-19 is occurring?** | **Yes** | **No** |

I verify that the above information is complete and accurate to the best of my knowledge. In good faith, I agree to comply with the practice standards in reducing the risk of transmission of the COVID-19 virus. I understand that misrepresentation on this form may put myself or others at risk for infection and potentially life-threatening complications.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**