MEMORIALCARE® MEDICAL GROUP

Name: _____

DOB: _____

MRN: _____

PATIENT SCREENING FORM

Ask the following questions for *every* patient at any clinical care setting to a MemorialCare facility or clinic.

1	**Has patient been/traveled outside the US within the last 30 days?** Patient Answer: YES NO (please circle)
2	**If so, when and where did you travel to?** When:_____ Where:_____
3	**Has anyone in your family or a close contact been outside the US within the last 30 days?** Patient Answer: YES NO (please circle)
4	**If so, when and where did they travel to?** When:_____ Where:_____
5	**Have you had potential contact with a person with known or suspected Ebola Virus Disease?** Patient Answer: YES NO (please circle)

If NO is the answer to **ALL** questions above, **STOP.**

If YES is the answer to **ANY** question above, **AND** they or a contact have traveled to a country on CDC's watch list for Ebola (including Guinea, Liberia, Sierra Leone), continue with step #6.

6	**a. Hand the patient a surgical mask to put on** **b. Move them immediately to a private isolation room or secluded area** **c. Follow STANDARD, CONTACT, and DROPLET precautions during ALL further assessment** **d. Notify provider / physician in charge** **e. Notify hospital or site leadership for further triaging** **f. Complete step 7 per site protocol, review findings with physician and leadership**
7	**Assessment: Take patient's temperature and ask the following questions:** **Does patient have (please circle):** Document temperature: _____ • Fever YES NO • Headache YES NO • Weakness YES NO • Joint & muscle pain YES NO • Vomiting YES NO • Diarrhea YES NO • Abdominal pain YES NO • Unexplained bleeding or bruising YES NO
	Date/Time/Signature: