HARTWOOD FOUNDATION INC.
COVID-19 HOME VISIT SCREENING FORM

PICK-UP DATE: _____ RETURN DATE: _____
SERVICE RECIPIENT'S NAME: _____ TEMP @ TIME OF PICK-UP: _____
FRIEND/FAMILY MEMBER'S NAME: _____ TEMP @ TIME OF PICK-UP: _____

SCREENING QUESTIONS FOR FRIEND/ FAMILY @ TIME OF PICK-UP:

Have you or anyone in your household experienced any of the following within the past 72 hours?

___ Shortness of Breath ___ New Loss of Taste or Smell ___ Sore Throat ___ Nausea
___ Fever or Chills ___ Cough or Congestion ___ Body Aches ___ Runny Nose
___ Headache ___ Vomiting ___ Diarrhea ___ Fatigue

Have you been around anyone that has flu-like symptoms or has tested positive for the Coronavirus in the past 2 weeks?

SCREENING QUESTIONS FOR SERVICE RECIPIENT @ TIME OF PICK-UP:

Has service recipient or anyone in the group home experienced any of the following within the past 72 hours?

___ Shortness of Breath ___ New Loss of Taste or Smell ___ Sore Throat ___ Nausea
___ Fever or Chills ___ Cough or Congestion ___ Body Aches ___ Runny Nose
___ Headache ___ Vomiting ___ Diarrhea ___ Fatigue

**** If any answers to above questions are YES, please have service recipient stay at the group home.***

SCREENING QUESTIONS DURING VISIT:

*** Please check and record the service recipient's temperature twice daily during the stay:**

Day 1 am Temp: _____ Day 2 am: _____ Day 3 am: _____ Day 4 am: _____ Day 5 am: _____ Day 6 am: _____
Day 1 pm Temp: _____ Day 2 pm: _____ Day 3 pm: _____ Day 4 pm: _____ Day 5 pm: _____ Day 6 pm: _____

Has service recipient OR anyone who's been around the service recipient experienced any of the following during the visit?

___ Shortness of Breath ___ New Loss of Taste or Smell ___ Sore Throat ___ Nausea
___ Fever or Chills ___ Cough or Congestion ___ Body Aches ___ Runny Nose
___ Headache ___ Vomiting ___ Diarrhea ___ Fatigue

**** If any answers to above questions are YES, please indicate if service recipient had close contact with the symptomatic person (cumulative 15 minutes exposure within 6 feet over a 24-hour period)? OR, if service recipient presented with any of the above, please specify date of onset.***

-- COMPLETE UPON RETURN FROM VISIT --

SCREENING QUESTIONS FOR FRIEND/ FAMILY @ TIME OF RETURN: TEMP @ TIME OF RETURN: _____

Have you or anyone in your household experienced any of the following within the past 72 hours?

___ Shortness of Breath ___ New Loss of Taste or Smell ___ Sore Throat ___ Nausea
___ Fever or Chills ___ Cough or Congestion ___ Body Aches ___ Runny Nose
___ Headache ___ Vomiting ___ Diarrhea ___ Fatigue

SCREENING QUESTIONS FOR SERVICE RECIPIENT @ TIME OF RETURN: TEMP @ TIME OF RETURN: _____

Has service recipient experienced any of the following within the past 72 hours?

___ Shortness of Breath ___ New Loss of Taste or Smell ___ Sore Throat ___ Nausea
___ Fever or Chills ___ Cough or Congestion ___ Body Aches ___ Runny Nose
___ Headache ___ Vomiting ___ Diarrhea ___ Fatigue

Has either service recipient or family /friend been around anyone with flu-like symptoms or has tested positive for the Coronavirus during the visit? If YES to any of the above, service recipient should be seen immediately for a COVID screening.

_____ _____
Family / Friend Signature *Date*

_____ _____
HFI Receiving Staff Signature *Date*