PATIENT SCREENING FOR COVID-19

Have you had any of these symptoms within the last 14 days

YES____NO____ Cough, shortness of breath or any trouble breathing?
YES____NO____ Fever chills or a sore throat?
YES____NO____ A new loss of taste or smell?
YES____NO____ Diarrhea or vomiting?

Have you been tested within the last 14 days for COVID-19?

YES___ NO____ RESULTS :

Have you been in contact with anyone who has had COVID-19 or any of any of the symptoms in the last 14 days

YES____NO____

Have you travelled within the past 2 weeks

YES____NO____

IF YOU DEVELOP SYMPTOMS BETWEEN NOW AND YOUR APPOINTMENT PLEASE CALL THE OFFICE AT (973) 838 - 8190