NEW JERSEY UROLOGY
Excellence In Care

COVID- 19 Patient Assessment On Check-In (For the Patient to fill out)

Patient Name:_____
Date of Birth: _____
Patient MRN: _____
Date of Appointment: _____

1. Are you or anyone accompanying you today currently experiencing any of the following symptoms or have you experienced the following symptoms within the last two weeks:

- ☐ Fever[1] (100 °F (37.77°C) or higher)
- ☐ Chills
- ☐ Muscle pain
- ☐ Sore throat
- ☐ New loss of taste or smell
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Diarrhea

2. Have you or someone you live with been tested for COVID-19 and are (1) waiting on results or (2) tested positive? ☐ Yes ☐ No
Date(s) tested _____

3. Have you been in close contact with a person known to have COVID-19 (2019 Novel Coronavirus) or that has been quarantined for Coronavirus? ☐ Yes ☐ No

4. Have you resided in a skilled nursing facility in the last 30 days? ☐ Yes ☐ No

If you checked YES to any ONE of the criteria listed above, even if you are asymptomatic, unless you need emergency care, please immediately let a NJU staff member know. Due to increased safety concerns, you will be asked to promptly leave the office and once safely home, call to reschedule.

Staff should refer to NJU's Patients Previously COVID-19 Positive SOP for purposes of rescheduling.

Thank you,

NJU

[1] If the location uses a contactless thermal scanner, the patient's temperature will not need to be recorded on this form.

Date: 3/12/2020. Updated: 4/2/20; 4/26/20; 5/7/20; 5/27/20; 6/30/20; and 7/7/20