eyes on hayden.

COVID-19 Pre-Screening Questionnaire

With the recent spread of COVID-19, we are taking additional steps to protect you, our patient, and the safety of our team. Please complete this questionnaire within 24-hours of your scheduled appointment or be prepared to complete it upon arrival to our office. If you answer "YES" to any of the following questions, contact our office immediately to discuss your options. We have special exam times set aside to safely accommodate you if you are at-risk or symptomatic and in need of urgent care. Please bring a copy of this completed questionnaire to your appointment.

1. Have you or anyone in your household been diagnosed with COVID-19, had a fever, cough, difficulty breathing, cold/flu-like symptoms, or a loss of taste/smell within the past 14 days?

   YES NO

2. Are you or anyone in your household currently providing care to anyone who has been diagnosed with COVID-19, had a fever, cough, difficulty breathing, cold/flu-like symptoms or a loss of taste/smell within the past 14 days?

   YES NO

3. Do you work or volunteer in a healthcare facility that directly exposes you to COVID-19?

   YES NO

4. Have you or anyone in your household traveled outside of the country in the past 14 days?

   YES NO

5. Please review the following questions to determine if you are considered an "at risk" individual:

   Do you have Heart Disease, Lung Disease, Diabetes, HIV or an autoimmune condition such as Lupus or Rheumatoid Arthritis? Are you currently undergoing Chemotherapy? Have you undergone an organ transplant or removal of your spleen? Are you on long term steroid treatment (prednisone) or immunosuppressive medications? Are you pregnant or is there any possibility that you may be pregnant?

   If you answered yes to any of the above questions, it is advised that you postpone your routine eye care until after you have been vaccinated or the risk of contracting COVID-19 is less prevalent. Would you like to reschedule your appointment to a later time?

   YES NO

I, _____, have answered the above questions accurately and truthfully. I understand that while Eyes on Hayden has taken the necessary steps outlined by the CDC to maintain a safe and healthy environment, my wellbeing cannot be guaranteed due to the highly transmissible nature of COVID-19. By signing this form, I agree to not hold Eyes on Hayden or any of its doctors or team members personally responsible should I, or someone I come in contact with, contract COVID-19.

_____ _____

Signature of Patient (or: ☐ Parent ☐ Guardian) Date:

Temp/O2/HR on arrival: / /