GASTRO HEALTH
FORMERLY GANV

Retroactive COVID-19 Questionnaire

Please use the below questionnaire to screen patients that had visit with us 7 days ago for procedures, office visits and infusions at JRO, JEC or FOO.

		Yes	If yes, when?	No
1	**Have you had a fever, or a temperature of 100.4 degrees or higher in the last 7 days? If yes, When?**			
2	**Have you had a cough, sore throat, shortness of breathing or difficulty breathing since you had a visit with us? If yes, when?**			
3	**Have you seen your doctor or gone to ER/Urgent care for those symptoms? If yes, when?**			
4	**Did you get tested for COVID-19? What was the result?**			
5	**What was your planned treatment or instructions given?**			
6	**Have you been quarentined since you had a visit with Gastrohealth?**			
7	**Have you come into close contact with someone that has been tested, diagnosed, quarentined or under investigation for COVID-19 since your last visit with Gastrohealth?**			

If a patient answers **yes** to any of the above questions, task the provider that last saw them with a copy to Miriam and Dao.

Last updated: 5/3/2020 MB