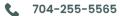


7	1875 Teachers House Rd NW Suite 70
	Concord, NC 28027





Patient Safety Screening COVID-19

Staff Name:		
Patient Name:		
Appointment D	ate/Tim	e:
Have you had c	contact w YES	vith anyone with Confirmed COVID-19/quarantined in the last 14 days? NO
Have you had F	Runny No YES	ose, Sore throat, Cough or Fever in last 14 days? NO
Are you curren	tly exper YES	riencing fever, difficulty breathing, cough or any flu like symptoms? NO
Have you or so	-	ou are in close contact with travelled to any foreign country in last 14 days?
	YES	NO
If Yes, where?		

Patient Signature