Infection Control Screening

Staff Name: _______________________________ Unit/Location: _______________________________

Phone #: _______________________________ Email: _______________________________

Date of Call Out: ________________________ Unit: _______________________________

Reason for Call: _______________________________

Has the staff person been told by a medical person they should be quarantined? ________________

Is the staff person able to work from home? ________________________________

Do you have any of the below signs or symptoms? (Please check all that apply)

__ Fever Temp: _______F  __ Cough  __ Difficulty Breathing/Shortness of Breath

__ Chest Congestion  __ Nasal/Sinus Congestion  __ Runny Nose

__ Poor Appetite  __ Dizziness  __ Body Aches

__ Chills  __ Headache  __ Nausea/Vomiting

__ Stomach Cramps/Abdominal Pain  _____ Other (describe): ___________________________

• Date Symptoms Began: ____________________________

• Did you work or attend any public areas since symptoms began? (if so, describe):

__________________________________________________________

• Who have you been in contact with since symptoms began?

__________________________________________________________

• Have you contacted or seen a doctor? Yes  No

• If you received a diagnosis, what was it?

__________________________________________________________

• Have you been hospitalized for this illness? Yes  No

• Have you traveled outside the country within the past 14 days? Yes  No

• If so, what country did you travel to?

__________________________________________________________

• What date did you arrive home: __________________________________

• Have you had close contact with anyone with a laboratory confirmed COVID-19 or Patient Under Investigation (PIU) for COVID-19? Yes  No  Please describe:

__________________________________________________________

Please complete the information and procedure on the reverse of this form.
Interviewer Information:

Name: _____________________________________  Unit/Location: _________________________

Phone #: _________________________________  Email: __________________________________

Please read the information below to the caller:
All forms are reviewed by The Office of the Medical Director.

Please call your medical provider if you have any symptoms of illness, but especially if you have fever, cough, shortness of breath, abdominal cramps, or sore throat, or if you have recently traveled from China, Iran, Italy, Japan, South Korea or other areas with widespread/ongoing community spread of COVID-19. The most current list of countries with travel restrictions can be found at cdc.gov.

Please follow your medical provider’s advice. If they feel that you should be tested for COVID-19, you need to call DPH to notify them you are being tested and follow any additional recommendations. Please call 1-866-408-1899.

Be advised that a call-out due to illness may require you to remain out of work for a period of two weeks or more. You will need to be cleared by The Office of the Medical Director before returning to work. At that time, you may need to provide the enclosed doctor’s note completed by your treating physician. If you feel you are able to return to work sooner, you may provide the aforementioned doctor’s note sooner. At that time, your request will be evaluated by The Office of the Medical Director.

Interviewer, please initial here after reading the above to the staff member: __________

***Recording interviewer, please scan and email this form to Mary.Wise@delaware.gov and April.Johnson@delaware.gov