Geer Nursing Visitor Screening Tool

Visitor Name:_____ Date of Assessment:_____

Scheduled Visit date and Time_____

Reason of Screening: ☐ Visitation with resident **Temperature** _____(staff must obtain upon arrival)

Have you received a diagnosis of Covid-19 in the last 90 days: Yes or No

1. ☐Are you able to wear and maintain proper fitting face covering? Including full coverage of Nose and mouth for the duration visit.
2. ☐Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?
3. ☐Have you been in close physical contact in the last 14 days with anyone who is known to have laboratory-confirmed COVID-19 OR anyone who has any symptoms consistent with COVID-19?
4. ☐Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?
5. ☐Are you currently waiting on the results of a COVID-19 test?
6. ☐Have you traveled in the past 10 days?
    a. ☐ High Risk (>10%) Country, State and County_____

Visitor vaccination status (optional information, not required for visitation)

☐ Low risk (Ex. Visitor received all required doses and two weeks have passed since second dose)

☐ High risk (Ex. Visitor is not vaccinated per guidelines; new admission cannot recall vaccination status)

Vaccination status unknown: _____

Questions # 2 – 6a. if any boxes are checked- entry may be denied and alternative arrangements will be made.

Completed BY Geer Staff:

7. **Resident** Mask wearing and hand hygiene.

    ☐ Low risk (ex. Resident maintains appropriate Mask use and performs hand hygiene)

    ☐ High risk (ex. Resident wanders, cannot maintain appropriate mask wearing or perform hand hygiene when prompted)

Conclusion: ☐ Approved for Apartment visitation ☐ Not approved – alternative visitation arrangements made

Brief Explanation (if necessary): _____

_____ _____ _____

Staff Member Conducting Assessment Title Signature