COVID-19 Screening Questions
for Medical Staff Assisting People Experiencing Homelessness

COVID-19 screening for patients who are homeless, including an examination of other underlying medical conditions and behavioral health needs, is necessary to confirm COVID-19 symptoms and determine next step referral. Screening must be completed by medical staff qualified to complete a COVID-19 medical evaluation and presumptive or final diagnosis.

Patient Name: ____________________________________________  DoB:____________________
Contact Number(s):__________________________________________

1. Has patient been diagnosed with COVID-19 within the past 14 days?
   ___ Yes ___ No

2. Has patient been tested for COVID-19 within the past 14 days and is awaiting test results?
   ___ Yes ___ No

3. Does patient have any of the following mild-to-moderate symptoms:
   • Fever (100.4°F or higher)?   ___ Yes ___ No
   • Cough that developed in the last 14 days?   ___ Yes ___ No
   • Shortness of breath?   ___ Yes ___ No

4. In the past 14 days, has patient had close contact* with a person who has tested positive for COVID-19, is being tested for COVID-19, or has exhibited the symptoms mentioned above while that person was ill? (close contact includes: living in same household, caring for, or being within 6 feet of for about 10 minutes or more.)
   ___ Yes ___ No

*CLOSE CONTACT includes:
   • Living in the same household as a sick person with COVID-19
   • Caring for a sick person with COVID-19
   • Being within 6 feet of a sick person with COVID-19 for about 10 minutes
   • Being in direct contact with secretions from a sick person with COVID-19 (e.g., being coughed on, kissing, sharing utensils, etc.)

5. Does patient have any of the following physical characteristics:
   ___ Over 60 years old
   ___ Serious underlying medical conditions (chronic or acute)
   ___ Pregnant
6. Does client have any of the following behavioral health characteristics:

___ Severe Mental Illness
   If checked, does the person appear to be managing their symptoms? ___ Yes ___ No
   If No, describe:

   ______________________________________________________

   If in treatment, who is the provider? __________________________

___ Substance Use Disorder
   If checked, what substance(s) is the person regularly using?

   ______________________________________________________

   If in treatment, who is the provider? __________________________

   Does patient take any prescription medications? ___ Yes ___ No

   Does patient have 14 day supply of any prescription or other substances needed if placed in isolation or quarantine? ___ Yes ___ No

7. In your medical judgement, could patient manage isolation or quarantine for a period of 14 days, not leaving their room at any time and with only minimal medical or behavioral health supports? ___ Yes ___ No

   What supports might be necessary to enable patient to manage quarantine or isolation for a period of 14 days?

   ______________________________________________________

8. Does patient give verbal or written consent for medical provider to contact the Homeless Hotline on their behalf to share screening results above and any other information necessary to determine next step referral and placement? ___ Yes ___ No

Qualified Medical Staff Who Completed Patient Evaluation & Credentials:

   Name:____________________________________________   Credential(s):_______________________

   Signature:____________________________________________________________________________