Revised 1/12/2021

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES: ***FRONT DOOR SCREENING TOOL***

Name: _____ Facility: _____ Date: _____

1. What is the purpose of your visit today? (this question helps to establish if patient, visitor, employee)

The following questions all refer to the past 14 days: Circle all symptoms that apply

2. Have you traveled to an area with widespread or sustained community transmission of Coronavirus? (within the last 14 days, refer to CDC ***and CT Governor's*** travel list). ***Also includes airline travel.***
Yes ☐ No ☐

3. Have you been in contact with a person that has suspected or **confirmed** Coronavirus?
Yes ☐ No ☐

4. Do you have congestion or running nose OR new onset headache OR nausea/vomiting/diarrhea OR fever (100.0 degrees F or greater) OR *chills OR* sore throat OR cough OR shortness of breath OR body aches OR fatigue OR loss of taste/smell?
Yes ☐ No ☐

5. If you have recently had **COVID Vaccine**, do you currently have fever OR cough OR runny nose OR shortness of breath OR chills OR sore throat OR loss of taste/smell
Yes ☐ No ☐

6. If you have recently had **COVID Vaccine**, do you currently have significant headache OR generalized muscle pain OR debilitating weakness
Yes ☐ No ☐

7. Temperature:_____

GUIDANCE:

Issue	**Response**
*If a non-DMHAS employee answers **"yes"** to any question **OR** has temperature of 100 F or higher*	Ask individual leave the property and advise to call their Primary Care Provider (PCP)
*If any DMHAS client answers "**yes**" to any question **OR** looks visibly ill **OR** If temp 100 F or higher*	Stay/go home, call PCP, and inform primary clinician
*If any staff member answers **"yes"** to **Qs 4 or 5** OR If temp 100 F or higher*	Stay/go home; follow protocol for testing and isolation/quarantine
*If **"yes"** to only Q2 or Q3*	Stay/go home. Self-quarantine at home and follow protocol. Inpatient staff with Yes to #3, follow specific protocol.
*If **"yes"** to any symptom on Q6*	Stay/go home; If symptoms resolve 72hrs or less after vaccination, return to work. If symptoms exceed 72hrs, do not return to work but contact PCP and supervisor.

Screening Staff Signature: _____ **Name:** _____