UCAS

UNIVERSITY CENTER FOR AMBULATORY SURGERY

Novel Coronavirus (Covid-19)
Pre-op Screening Form

TEMPERATURE: _____

Protocol: All patients will be screened pre-operatively for exposure risk to Covid-19 and symptoms of respiratory illness.

	Questions	**Yes**	**No**
1.	Have you, your companion / family member coming to the facility with you on the day of surgery, been in close physical contact with a person laboratory-confirmed with Covid-19 in the LAST 14 DAYS?		
2.	Have you, your companion to the surgery center / a family member you have been in direct contact with, been in close physical contact with a person who is currently being quarantined for Covid-19 exposure IN THE LAST 14 DAYS?		
3.	Have you or your companion to the surgery center traveled internationally or returned from a state included on the travel advisory list by New Jersey for COVID-19?		
4.	Have you or your companion on the day of the surgery/ a family member you have been in direct contact with, had any of the following symptoms in the past 3 days that are not caused by another condition?		
•	Fever (Temperature of =or> 100.4) or chills		
•	Sore throat/ Cough		
•	Shortness of breath		
•	Loss of smell or taste		
•	Muscle pain		
•	Headache		
5.	Within the past 14 days, has a public health / medical professional advised you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?		

If the answer is NO to all the above, you may come in on the scheduled surgery date.
If the answer is YES to any of the above, please contact your surgeon immediately.

		Yes	**No**
1.	Have you been tested for Covid-19 in the past 6 days? Date of test/facility:		
2.	Was the test negative?		
3.	If your test is negative, please self-isolate at home until you have your surgery to avoid possible exposure to Covid-19.		

Comments: _____

If your Covid-19 test is POSITIVE, you will be instructed to contact your surgeon to reschedule your procedure.

_____/_____
Patient signature **Date**

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