10.03.2022

Staglin Center Pre-Appointment Screening Form

Please administer this questionnaire to participant's the day before/morning of their scheduled MRI appointment, but before they arrive at CCN. If answers indicate potential illness, please reschedule appointments for when your participant is feeling better.

Please read each question carefully and circle the answer that applies. No health information or questionnaire answers will be shared with anyone outside of your organization.

Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?		
• Fever or chills	Yes	No
• Cough	Yes	No
• Shortness of breath or difficulty breathing	Yes	No
• Fatigue	Yes	No
• Muscle or body aches	Yes	No
• Headache	Yes	No
• New loss of taste or smell	Yes	No
• Sore throat	Yes	No
• Congestion or runny nose	Yes	No
• Nausea or vomiting	Yes	No
• Diarrhea	Yes	No

Have you tested positive for COVID-19 in the past 10 days?	Yes	No
Are you currently awaiting results from a COVID-19 test?	Yes	No
Have you been diagnosed with COVID-19 by a licensed healthcare provider (for example, a doctor, nurse, pharmacist, or other) in the past 10 days?	Yes	No
Have you been told that you are suspected to have COVID-19 by a licensed healthcare provider in the past 10 days?	Yes	No