ASTHMA, ALLERGY CARE CENTER OF FLORIDA

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www.asthmaallergycare.com

TRIAGE FORM

Date:_____ Time: _____

Patient Name: _____PT ID #:_____
DOB: _____
Insurance: _____
Temp: _____
Practice: _____

Are you having any symptoms of an acute lower respiratory illness - for example a fever, cough or shortness of breath? YES ☐ NO ☐ (explain)_____.

Have you traveled to or from an affected geographic area with widespread community transmission? YES ☐ NO ☐

Have you had any International travel or have you been on a cruise? YE5 ☐ NO ☐

Have you had a close contact with a laboratory confirmed COVID-19 case? YES ☐ NO ☐

Have you been hospitalized with an acute lower respiratory illness of unknown origin? YES ☐ NO ☐

Are you over the age of **65** with a chronic health condition? Such as heart disease, high blood pressure, diabetes, lupus, rheumatoid arthritis, or immune problems? YES ☐ NO ☐

Have you had sudden, acute loss of sense of taste or smell? YES ☐ NO ☐

Have you had Nausea, Vomit or Diarrhea? YES ☐ NO ☐

Are you Immunocompromised? YES ☐ NO ☐ (explain)_____.

Have you had Covid-19 antibody testing performed? When? Date:_____. YES ☐ NO ☐

What was your result of the Covid-19 antibody test? _____.

Chief complaint:

_____

_____

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