COVID-19 SCREENING FORM

For Admission to New York State OMH Adult, Forensic, and Child Psychiatric Center's Inpatient Services

Updated March 21, 2022

This screening form is required to be completed PRIOR to acceptance for admission or re-admission. Please complete and forward to the State-Operated Psychiatric Center. The information below will help determine appropriate unit placement and Psychiatric Center preparation.

Patient Name: ________ Patient's Date of Birth: _____

1. **Is the patient currently recovering from CONFIRMED COVID-19 illness?**

   ☐ No ☐ Yes. If Yes, please complete the following:

   - Has the patient been without fever for at least 3 days (72 hours) without the use of fever-reducing medications?
     ☐ Yes ☐ No
   - Have the patient's respiratory symptoms (e.g., cough, shortness of breath) improved?
     ☐ Yes ☐ No
   - Have at least 10 days passed since the patient's COVID-19 illness symptoms first appeared?
     ☐ Yes ☐ No
   - Does the patient have a documented negative COVID-19 follow-up test:
     ☐ Yes ☐ No

     If Yes, date of negative follow-up test: _____ Type of test: _____

2. **Has the patient had direct contact with a person confirmed or suspected to be positive for COVID-19 within the past 10 days?**

   ☐Yes ☐No

3. **Is the patient currently (within past 72 hours) experiencing any of the following symptoms?**

   - Fever > 100.0ºF ☐ Yes ☐ No
     - If yes, please detail the last 36 hours of temperature recordings:
   - Chills ☐ Yes ☐ No
   - Repeated shaking with chills ☐ Yes ☐ No
   - Cough ☐ Yes ☐ No
   - Shortness of breath or difficulty breathing ☐ Yes ☐ No
     - If yes, please describe if the patient has any significant comorbidity (i.e., pulmonary conditions, cardiovascular disease, diabetes mellitus, immunosuppression, etc.):

- If yes, please also indicate the most recent pulse oximetry reading (SpO2):

- 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

4. **For patients transferred from an Article 28/31 hospital inpatient setting to a State Psychiatric Center (PC), a COVID-19 NAAT/PCR test within 48 hours prior to admission or an antigen test on the day of transfer must be completed. For admissions from other settings, an antigen test 24 hours prior to admission is adequate.** *Note: If the patient has tested positive for COVID-19 within the previous 90 days, an antigen test is recommended.*

   Date of Planned Transfer/Admission to State PC: _____

   Date Test Obtained (or scheduled): _____

   Type of Test: _____

   Test result: ☐ Positive ☐ Negative ☐ Result pending ☐ Test not yet obtained

   Have there been any positive tests in the last 10 days? ☐ Yes ☐ No

   If yes, what are the date(s), type(s), and results of the tests in the last 10 days?

   Have test result(s) been sent to the State PC?

   ☐ Yes ☐ No, will be sent when obtained

   If a COVID-19 test was NOT obtained, please indicate why

   ☐ The patient refused the test

   ☐ The patient is being admitted from a setting where testing is not available. Please provide details as to this setting:

5. **Is the patient up to date on COVID-19 vaccinations? (Up to date means a person has received all recommended doses in their primary series COVID-19 vaccine, and a booster dose when eligible.)**
   ☐ Yes ☐ No

Name of the Referring Facility: _____
Name of the Referring Physician/Nurse Practitioner: _____
Contact Telephone Number of Referring Physician/Nurse Practitioner: _____
Referring Physician/Nurse Practitioner Signature: _____
Date Form Completed: _____
Time Form Completed (Please use military time, e.g., 14:06): _____