Shelter Screening Tool Questions

Name:		**Date:**
Sex: M F	**Date of birth:**	**Phone:**
Head of household: ◯ Self ◯ Other:		**Service point number:**

Welcome! Please answer these questions to assure that you and others are healthy during your stay with us.

Questions	Select One	Comments
Do you have any of the following?		
1. Within 14 days of travel to anywhere w/known community transmission of COVID-19 OR contact with confirmed COVID-19	◯ Yes ◯ No	
2. Fever [actual or subjective]?	◯ Yes ◯ No	
3. Cough?	◯ Yes ◯ No	
4. Shortness of breath?	◯ Yes ◯ No	
If yes to #3 above, ask 5-7		
5. Have a cough for more than 2 weeks?	◯ Yes ◯ No	
6. Have severe coughing spasms?	◯ Yes ◯ No	
7. has the person ever been told they have tuberculosis by a medical professional?	◯ Yes ◯ No	
Ask 8-10 for all		
8. Does the person feel sick today?	◯ Yes ◯ No	
9. Does the person want to see a doctor?	◯ Yes ◯ No	
10. Does the person want to see a doctor?	◯ Yes ◯ No	
Ask 11 for females only		
11. Are you pregnant?	◯ Yes ◯ No ◯ Maybe	

Referred to provider:

San Diego County Tuberculosis Clinic: 3851 Rosecrans St, San Diego, CA | 619-692-5565
Urgent Care:
Medical Provider/Non urgent: (specify location)
Emergency Room: (specify hospital), ☐ check if sent via ambulance