Screening Questionnaire for coronavirus Disease (COVID-19)

Frequently asked questions

1. Have you or anyone in your household traveled to China or a Community that is known to be infected in the United States? Yes or No

2. Have you been in physical contact with a person that traveled to China or a Community that is known to be infected in the United States? Yes or No

3. Do you have any of the following symptoms to include but not limited to:

- Fever yes or No
- Cough yes or No
- Difficulty breathing yes or No
- Pneumonia in both lungs yes or No
- Fatigue yes or No
- Sore Throat yes or No
- Sneezing yes or No

4. Do you have a fever greater than 100 degrees F? Yes or No

I have answered the above questions truthfully and to the best of my knowledge.

__________________________ ______________

Inmate Signature Date

* If the answer is "**YES**" to any of the above questions, Notify the responsible Nurse and the Captain.

__________________________ ______________

Officer Signature Date

HAMPTON DETENTION CENTER
INITIAL INTAKE/ TRIAGE QUESTIONS
(TO BE ASKED OF TRANSPORTING OFFICER)

1.	Has this person been injured or have any observable medical problems?	Yes	No
	If yes, explain:		
2.	Has this person exhibited any mental health/suicidal behaviors?	Yes	No
	If yes, explain:		
3.	Has this person tried to escape or acted violently?	Yes	No
	If yes, explain:		
4.	Is there any other information about this individual which we need to know?	Yes	No
	If yes, explain:		
5.	Has a NCIC check been run?	Yes	No
	If yes, explain:		
6.	Are there any active warrants?	Yes	No
	If yes, explain:		

Subject Name: Date: Time:

Transporting Officer: Agency:

Intake Officer:

Other Comments:

INITIAL MEDICAL INTAKE & HISTORY

Name______________________ J#____________ Sex____________

Age____ Examiner's Name: ____________________ Date____________

"Was Inmate taken to ER prior to booking? Y or N (If yes, clearance form must be placed in Nurse's box)

Booking Officer's Visual Opinion

1. Is the inmate conscious	Yes or No
2. Does the inmate have pain, bleeding or other symptoms needing Emergency Services?	Yes or No
3. Are there visible signs of trauma or illness requiring immediate Emergency or Doctor's Care?	Yes or No
4. Is there obvious fever, swollen lymph nodes, jaundice or other evidence of infection which may spread through facility?	Yes or No
5. Is the skin in good condition & free of vermin? (If no, explain)	Yes or No
6. Does the inmate appear to be under the influence of alcohol?	Yes or No
7. Does the inmate appear to be under the influence or barbiturates, heroin or any other drug?	Yes or No
8. Are there any visible signs of Alcohol/Drug withdrawal symptoms?	Yes or No
9. Does the inmate's behavior suggest the risk of suicide?	Yes or No
10. Does the inmate's behavior suggest the risk of assault to staff or other inmates?	Yes or No
11. Is the inmate carrying medication or does the inmate report being on medication which should be administered or available?	Yes or No
Officer-Inmate Questionnaire	
12. Are you presently taking any medication for diabetes, heart disease, seizures, arthritis, asthma, ulcers, HBP, or psychiatric disorder? (List condition)	Yes or No
13. Do you have a special diet prescribed by a physician? (If so, list)	Yes or No
14. Do you have a history of Communicable Disease? (ex. HIV/AIDS, MRSA, TB, STD)	Yes or No
15. Have you recently been hospitalized or seen a medical or psychiatric Dr? (If so list)	Yes or No
16. Have attempted suicide? If so, when? Do you still feel suicidal?	Yes or No
17. Are you allergic to any medications, foods, plants, or fabrics? (If so, list)	Yes or No
18. Have you fainted recently or had a recent head injury? (If so, when?)	Yes or No
19. Do you have Epilepsy, history of TB, Diabetes, or Hepatitis? (If so list)	Yes or No
20. Females: Are you pregnant? How many months?	Yes or No
21. Females: Are you on birth control?	Yes or No
22. Females: Have you recently given birth? How long ago?	Yes or No
23. Do you have a painful dental condition?	Yes or No
24. Do you have a complaint of sore throat, fever, or any condition that may spread?	Yes or No
25. Do you have any other medical conditions or problems we should know about?	Yes or No

List any medications IM is presently taking______________________________

Any History of Narcotic Use? Y or N______________________________

Dietary Preferences? ______________________________

I agree that the above information can be released to any counselor or attending physician

______________________ ______________________

Inmate Signature Officer's Signature

Southern Health
Partners

PATIENT'S CONSENT FOR TREATMENT

The undersigned, being in the custody of the County Jail, hereby authorize and request that all medical records and/or information, wherever located, including any hospitals or medical doctor or any other place where medical records may be located, be released to the County Jail medical department for use by the medical department regarding any treatment to be reviewed while in custody. I understand I will provide this information to the medical department.

I further authorize the County Jail medical department to evaluate and treat any condition that I may have or develop while in the custody of the County Jail. My signature below hereby authorizes other healthcare providers to provide medical information regarding my medical condition to the staff of Southern Health Partners while in the custody of the County Jail. This care may result in services being provided outside the County facility which may include but not be limited to hospitals, clinics and physicians' offices. Furthermore, my signature below provides consent for medical photographs to be made for me. I understand that the photographs and information may be used in my medical record for the purposes of documentation and/or treatment. I acknowledge no guarantee or assurance has been made as to the desired result that may be obtained.

I have been made aware of how to request medical services while incarcerated, and am aware I have the right to refuse treatment. I may be required to sign a Refusal of Treatment form should I refuse medical treatments and/or medications.

I release Southern Health Partners, Inc., its staff, the County, the Sheriff (where applicable), his/her staff from all responsibility and I assume personal responsibility for the conditions that may occur as a result of my not requesting services and/or refusing treatment as prescribed by the medical staff of the facility and/or outside consultation services.

Patient's Signature: ______________________________ Date: ________

Printed Name: ______________________________ Patient's DOB: ________

Witness: ______________________________ (Officer/Medical Signature)

Note: This completed form must be given to the medical department for inclusion in the patient's confidential medical file Please provide a copy of this form, upon request, if patient is transported for outside medical services.