UTAH DEPARTMENT OF HEALTH

Long-Term Care Facility Visitor Screening Tool

Visitor Name: _____ **Date/Time:** _____

1. Have you had **any** of the following symptoms in the past 48 hours?
   - Fever or chills
   - Cough
   - Shortness of breath
   - Fatigue
   - Muscle or body aches
   - Headache
   - New loss of taste or smell
   - Sore throat
   - Congestion/runny nose
   - Nausea or vomiting
   - Diarrhea

   ☐ YES, STOP DO NOT ENTER THE FACILITY ☐ NO, Proceed to next question

2. In the past 14 days, has anyone in **your home** or anyone you have **been around** tested positive or had symptoms of COVID-19 (see above)? Note: Visitors who have had close contact (15 minutes or more within six feet of a person with COVID-19 *over a period of 24 hours)* to another person infected with COVID-19 should not visit,

   ☐ YES, STOP CHECK WITH FACILITY STAFF BEFORE ENTERING FACILITY ☐ NO, Proceed to next question

3. In the past 10 days, have you **tested positive** or are you **awaiting test results** for COVID-19?

   ☐ YES, STOP DO NOT ENTER THE FACILITY ☐ NO, Proceed to next question

4. Have you traveled either within (domestic) or outside (international) of the United States in the past 10 days? If so, check 'YES' unless **EITHER** of the following exceptions apply:
   - I was fully vaccinated for COVID-19 at least 14 days before my **domestic** trip, **OR**
   - I was fully vaccinated for COVID-19 at least 14 days before my trip AND I tested negative for COVID-19 at least 3 days after my **international** trip, **OR**
   - I have not traveled for at least 7 days **AND** I tested negative for COVID-19 at least 3 days after my trip

   ☐ YES, STOP DO NOT ENTER THE FACILITY ☐ NO, Present your completed form to facility staff for review

This portion is for facility review only

Criteria for visitation met (circle one)?	Yes	No
If no, was facility administration notified (circle one)?	Yes	No
Reviewed by: _____	Date/Time _____	

Last updated: 12/16/2021