Temp________

Patient Advisory and Acknowledgment
Receiving Ophthalmic Treatment/Exams During the COVID-19 Pandemic

Valued Patient:

You have come to our office today for an ophthalmic evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with California Department of Public Health and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

______________________________ ______________
PATIENT / GUARDIAN DATE

PLEASE ANSWER "YES" OR "NO" WITH YOUR INTIALS, TO THE FOLLOWING QUESTIONS:

Question	Yes	No
Have you been diagnosed positive for the COVID-19 virus at anytime?	______ Yes	______ No
Are you currently awaiting the results of a COVID-19 test?	______ Yes	______ No
Have you been in contact with any confirmed COVID-19 positive patients?	______ Yes	______ No
Do you have a fever, or have you had a fever in the last 14 days?	______ Yes	______ No
Do you have shortness of breath, or difficulty breathing?	______ Yes	______ No
Do you have a cough?	______ Yes	______ No
Do you have other flu like symptoms such as sore throat, runny nose, headache, upset stomach or fatigue?	______ Yes	______ No
Have you experienced recent loss of taste or smell?	______ Yes	______ No
Within the last 14 days, have you travelled within the United States or to any foreign country?	______ Yes	______ No

If so, where and when? ____