Penn Home Infusion Therapy

EBOLA SCREENING

Patient Name: _____ DOB: _____

Date and Time of Screening: _____

Name of the Person You Spoke to Regarding this Screening:_____

Assessment by: _____

Ebola Screening Question(s)	
In the past 3 weeks, have you or anyone in your home traveled to Mali, Guinea, Liberia or Sierra Leone OR been in the presence of anyone who has traveled to Mali, Guinea, Liberia or Sierra Leone?	☐ YES ☐ NO
If Yes to the above question, then ask: Have you or anyone in your home had fever, headache, muscle pain, diarrhea, vomiting, weakness, abdominal pain or unusual bleeding in the last 3 days.	☐ YES ☐ NO

If YES to BOTH Screening Questions, Follow the Guidelines Below:

Which Symptoms are present?	☐ Fever ☐ Headache ☐ Muscle Pain ☐ Diarrhea ☐ Vomiting ☐ Weakness ☐ Abdominal Pain ☐ Unusual Bleeding
Document how long each symptom has been present:	
Inform the patient that someone will call them back with scheduling information.	☐ YES ☐ NO
Contact Dr. Anne Norris at 610-331-6020. If not available call 215-614-0524.	☐ YES ☐ NO