The Plastic Surgery Experts

Mark Mandell-Brown, M.D.

COVID-19 SCREENING

Patient Name___________________________________ Date of Birth_____________________________

Temperature_____________________

Have you had any of the following symptoms?

Symptom		
Chills	Y	N
Headaches	Y	N
Loss of smell	Y	N
Fever	Y	N
Sore Throat	Y	N
Cough	Y	N
New shortness of breath	Y	N

If YES to any, restrict the patient from entering the building.

Have you been exposed to anyone with confirmed COVID-19? Y N

If YES, please exit building and self-quarantine for 14 days.

I ____ understand that the Mandell-Brown Plastic Surgery Center is doing everything possible to eliminate the risk of spreading SARS-COVID-2 virus. However, I have been informed that I assume responsibility for hand washing, wearing my own protective wear, and taking my own safeguards. By visiting the Mandell-Brown Plastic Surgery Center I release them of any exposure liability that may affect my health.

____ ______________________________

Name Date

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