COVID-19 Registrant Wellness Check

Registrant: _____ Representative: _____

Assessment Date(s): _____Time(s):_____

Mode of contact: __Phone __Email / Contact with: __ Registrant __Representative __Other

1.	Are you, or any one you are living with, having flu-like symptoms, such as: fever, chills, repeated shaking with chills, cough, shortness of breath, muscle pain, headache, sore throat, GI symptoms, or new loss of smell and taste?	Yes	No
2	Have you, someone with whom you've had contact or anyone you are living with, been suspected of having or been diagnosed with Coronavirus?		
3	Have you or someone with whom you have had contact been asked to self-quarantine?		
4	Have you or someone with whom you have had contact or anyone you are living with traveled out of the state or country in the last 14 days?		

Check all that apply:

- ○ Limited or no social supports/family while homebound
- ○ ADL/IADL needs NOT being met
- ○ Mental health concerns and/or emotional distress
- ○ Social isolation/loneliness and/or failure to heed sheltering in place (reg. or caregivers)
- ○ Lack of activity
- ○ Unstable or unsafe environment
- ○ Financial insecurity/lack of resources while homebound
- ○ Food insecurity – lacks supplies/unable to prepare/unable to safely reheat/dependent
- ○ Lack of transportation to medical visits and other essential errands (Ex: shopping)
- ○ Concerns with medication management (administration & availability)
- ○ Fall risk – fell or tripped/home presents risks/lacks support
- ○ Diabetic management: potential challenges with diet/monitoring/medications __ N/A
- ○ Hypertension management: potential challenges with diet/monitoring __ NA
- ○ Multiple chronic conditions and/or ADL/IADL challenges

SUMMARY OF IDENTIFIED PROBLEMS AND ACTION PLAN TO ADDRESS AS NEEDED (use progress notes and care plan to provide detail of assessed needs and document provider's response over time) _____

_____

_____

Staff Signature/Title/Date _____