

# 24hr Infectious Disease Subject Screening Questionnaire

This should be completed by a member of the research team 24 hours prior to the imaging visit. If the subject has any symptoms, you must reschedule their imaging appointment for a minimum of 10 days after their symptoms started and 72 hours after fever has subsided (without fever suppression).

There will be no cancellation fee for to reschedule these cases.

Thank you!

## THE MOUNT SINAI HEALTH SYSTEM

### BIOMEDICAL ENGINEERING AND IMAGING INSTITUTE

### INFECTIOUS DISEASE SCREENING TOOL

Date of Imaging Appointment: [appointment\_date\_intro]

Subject Name: [subject\_lastname\_intro], [subject\_firstname\_intro]

Birthdate: [subject\_dob\_intro]

Insurance Gender (Gender selected under insurance): [insurance\_gender\_intro]

Gender Preferred Pronoun: [gender\_identity\_intro]

Study Principal Investigator: [pi\_name]

Study Coordinator/Nurse: [study\_coordinator]

Medical Record Number (MRN): [mrn\_intro]

### Subjects/Coordinators should answer ALL questions below:

Have you been diagnosed with COVID-19 (Coronavirus)? ☐ Yes ☐ No

1. Do you have a Fever (temperature of at least 100F)? ☐ Yes ☐ No

**STOP! If you answered YES to question 1 and have a Fever (100.4F) or feel hot please let staff know immediately for further instructions and contact your requesting physician who will need to contact the Radiology Department.**

2. Do you have any of the following symptoms (please check all that applies):

- ☐ Cough
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Rash
- ☐ Vomiting
- ☐ Diarrhea
- ☐ None of the above

2a. If you answered yes to question #2, how long have you had these symptoms:

\_\_\_\_\_

1 3. Have you traveled outside the United States in the past 14 days (2 weeks)?

☐ Yes ☐ No

3a. If YES, please list countries:

\_\_\_\_\_

2 4. Has a close contact (household member) traveled outside the United States in the past 14 days?

☐ Yes ☐ No

4a. If YES, please list countries

\_\_\_\_\_

5. Have you had close contact in the past 14 days (2 weeks) with a person with (please check all that applies):

- ☐ Coronavirus (COVID-19)
- ☐ Middle Eastern Respiratory Virus (MERS)
- ☐ Ebola/Lassa/Marburg
- ☐ Measles,
- ☐ Mumps
- ☐ Chickenpox
- ☐ Any other known infectious disease?
- ☐ No contact with infectious disease

5a. Please explain if "Any other known infectious disease" was selected:

\_\_\_\_\_

6. If you indicated that you came in contact with any individual in the past 14 days that may have had or still has any of the listed viruses or infectious diseases, please indicate when was the most recent?

\_\_\_\_\_

Did you require assistance in completing this questionnaire? [need\_help\_intro]

FOR SUBJECTS REQUIRING ASSISTANCE TO COMPLETE THIS QUESTIONNAIRE

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Indicate relationship to Subject: [relationship\_to\_subject\_intro]

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Name of individual completing this questionnaire: [completing\_name\_intro]

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Date questionnaire is completed: [form\_date]

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Time questionnaire is completed: [completing\_time\_intro]

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PLEASE MAKE SURE TO REVIEW ALL QUESTIONS AND ANSWERS BEFORE SUBMITTING

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FOR INTERNAL USE ONLY  
Tech/ RN Verification

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Question 1. Do you have a Fever (temperature of at least 100F?

Was answered "YES"

(Tech comment on how this was resolved)

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Question 2. Do you have any of the following symptoms (please check all that applies):

- 1, Cough
- 2, Shortness of breath
- 3, Sore throat
- 4, Rash
- 5, Vomiting
- 6, Diarrhea
- 99, None of the above

Was answered with a selection

(Tech comment on how this was resolved)

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Question 2a. If you answered yes to question #2, how long have you had these symptoms:

Was answered with an explanation

(Tech comment on how this was resolved)

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Question 3. Have you traveled outside the United States in the past 14 days (2 weeks)?

Was answered "YES"

(Tech comment on how this was resolved)

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Question 4. Has a close contact (household member) traveled outside the United States in the past 14 days?

Was answered "YES"

(Tech comment on how this was resolved)

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Question 5. Have you had close contact in the past 14 days (2 weeks) with a person with (please check all that applies):

- 1, Coronavirus (COVID-19)
- 2, Middle Eastern Respiratory Virus (MERS)
- 3, Ebola/Lassa/Marburg
- 4, Measles,
- 5, Mumps
- 6, Chickenpox
- 7, Any other known infectious disease?
- 99, No contact with infection disease

\_\_\_\_\_  
(Tech comment on how this was resolved)

Was answered with a selection

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Name of MRI or CT Technician Reviewing Infectious Disease Screening Tool:

\_\_\_\_\_  
((First and Last name))

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Are you a:

☐ CT Technician    ☐ MRI Technician

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Name of Registered Nurse (RN) Reviewing Infectious Disease Screening Tool:

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((First and Last name))