|  |
| --- |
| **Attachment B: LTCOP COVID-19 Symptom Self-Assessment and Affirmation**  |
| *Ombudsman representatives* ***must*** *complete, sign, and submit this questionnaire to your supervisor on the day of the facility visit.* |

|  |  |  |  |
| --- | --- | --- | --- |
| **LTCOP Representative Name:** |       | **Date:** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Temperature:** |       | **Date of last COVID-19 Test:** |  | **Result:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **In the last 2 – 14 days, have you had:** | **Please**  | **Circle:** | **Comments:** |
| Fever or chills | YES | NO |  |
| Cough | YES | NO |  |
| Shortness of breath  | YES | NO |  |
| Difficulty breathing | YES | NO |  |
| Fatigue | YES | NO |  |
| Muscle or body aches | YES | NO |  |
| Headaches | YES | NO |  |
| New loss of taste or smell | YES | NO |  |
| Sore throat | YES | NO |  |
| Congestion or runny nose | YES | NO |  |
| Nausea or other digestive symptoms | YES | NO |  |

*I affirm and certify that the information and answers to questions herein are complete, true, and correct to the best of my knowledge and belief.*

|  |  |
| --- | --- |
| **Ombudsman Representative Signature:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Reviewed by:** |  | **Reviewer Signature:** |  |