BAYADA®
Home Health Care

BAYADA Home Health Care COVID-19 Employee Assessment Tool

Employee name: _____

If you answer "Yes" to any of the following questions, please stop and call your office immediately for direction before providing client care.

1. Do you have any of the following symptoms or changes in condition?
    - Fever or chills
    - Cough
    - Shortness of breath or difficulty breathing
    - Fatigue
    - Muscle or body aches
    - Headache
    - Sore throat
    - New loss of taste or smell
    - Congestion or runny nose
    - Nausea or vomiting
    - Diarrhea

2. Within the past 10 days, have you:
    - Tested positive for COVID-19
    - Been tested for COVID-19 *because you developed symptoms* and are awaiting results
    - Been asked to self-quarantine

3. Have you been in contact with anyone within the past 10 days who is presumed positive or tested positive for COVID-19 infection?

4. Within the past 10 days, have you traveled to a different state or traveled internationally ?