REM DIAGNOSTICS
SPECIALISTS IN SLEEP

Patient Questionnaire Regarding Covid-19

Name_____ **Date**_____

Are you experiencing any of the following symptoms? Temperature reading _____

Y or N	Fever or chills
Y or N	Cough
Y or N	Shortness of breath or difficulty breathing
Y or N	Fatigue
Y or N	Muscle or body aches
Y or N	Headache
Y or N	New loss of taste or smell
Y or N	Sore throat
Y or N	Congestion or runny nose
Y or N	Nausea or vomiting
Y or N	Diarrhea
Y or N	Had an exposure to a person known to have COVID-19 within the last 2 weeks

Release of Liability-COVID-19 Waiver

I am aware that there is currently a worldwide pandemic occurring known as COVID-19. I hear by acknowledge that by coming to the office of REM Diagnostics Inc; I am assuming the same risks as the general population in other environments or situations in which COVID-19 may be present. I am aware of the potential risks of exposure to COVID-19 in prominent locations both outside and within the office. It is clear to me that REM Diagnostics is doing everything they can to ensure proper policies and procedures to reduce the risk of infection. In spite of the implementation of risk management procedures and other controls, there is no way to ensure that I will not be exposed to the virus by virtue of my presence in the office or getting a procedure done. The risks associated with the contraction COVID-19 virus, including hospitalization and death. I am aware of these possibilities, and I am making an informed choice to enter the office of REM Diagnostics. By signing this form, I am deemed to have assumed the risk of exposure in the unfortunate event that such exposure occurs. Additionally, I will not hold REM Diagnostics, Inc., legally responsible if I contact COVID-19.

Signature_____ Date_____