|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Covid-19 Patient screening**  Name: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_  Do you have a fever or have you felt hot or feverish recently (14-21 days)?  Yes  No  Are you having shortness of breath or other difficulties breathing?   |  |  |  | | --- | --- | --- | | Yes No | |  | |  | |  | | |   Do you have a cough?  Yes  No  Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?   |  |  | | --- | --- | | Yes  No  Have you experienced recent loss of taste or smell? |  | |  |  | | Yes  No |  |   Have you had any contact with any confirmed COVID-19 positive patients?   |  |  | | --- | --- | | Yes  No |  |   Is your age over 60?  Yes  No  Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?  Yes  No  Have you traveled in the past 14 days to any regions affected by COVID-19?  Yes  No |  |  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_