|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 [ ]  NoAre you having shortness of breath or other difficulties breathing?

|  |  |
| --- | --- |
| [ ] Yes [ ] No |  |
|  |  |

Do you have a cough?[ ]  Yes [ ]  NoDo you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue?

|  |  |
| --- | --- |
| [ ]  Yes [ ]  NoHave 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 [ ]  NoHave you traveled in the past 14 days to any regions affected by COVID-19?[ ]  Yes [ ]  No  |  |  |

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