Coronavirus COVID-19

Leaflet 2A: SCREENING FORM FOR PATIENTS/ACCOMPANYING PERSONS (D, H, A, T, DD, P)

Name of the person screened: ★ _____

PRE-APPT.

Date :

★ Please indicate if the above name refers to the screening form for the patient or the accompanying person: ☐ Patient ☐ Accompanying person

Patient Info

First name: _____ Last name: _____

Phone: _____ email: _____

	PRE-APPT.
1 Have you tested positive for COVID-19 in the last 21 days or have you been told that you should be tested?	☐ Yes ☐ No
Do you have the following conditions:	
2 Fever? (over 38 °C or 100.4 °F)	☐ Yes ☐ No
3 New cough or worsening chronic cough?	☐ Yes ☐ No
4 Breathing difficulties (e.g., shortness of breath, difficulty speaking)?	☐ Yes ☐ No
5 Sudden loss of smell (with or without loss of taste)?	☐ Yes ☐ No
6 Muscle pain, headache, intense fatigue or significant loss of appetite?	☐ Yes ☐ No
7 Sore throat?	☐ Yes ☐ No
8 Diarrhea?	☐ Yes ☐ No
9 Do you have a health issue that might explain the symptoms described above? If so, specify: _____	☐ Yes ☐ No
10 Have you been in close contact (at least 15 minutes within 2 meters) with a confirmed or probable case of COVID-19? ▲	☐ Yes ☐ No
11 Are you a healthcare worker who has been in contact with COVID-19?	☐ Yes ☐ No

Signature of the person who completed the form (patient or office personnel):

Signature pre-appt.: _____

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