SA018196

UnitingCare

# CORONAVIRUS (COVID-19) SCREENING

Surname: ..... MR/UR no.: .....

Given name(s): .....

Address: .....

Postcode: ..... DOB: .....

Doctor: .....

(OR AFFIX PATIENT IDENTIFICATION LABEL HERE)

» To ensure the health and safety of yourself and others, it is important that this document is completed in full to the best of your knowledge.

» This form is to be completed within 24hrs prior to your admission. **Please bring this form on your day of admission.**

» If you have any of the below symptoms, please contact your doctor and discuss specific advice for your admission.

» If you require assistance, please ensure someone is available until you are cleared for admission.

1. Reason for admission:

2. Please tick if you have any flu-like symptoms or symptoms listed below:

- ☐ Acute respiratory distress
- ☐ Fever
- ☐ Anosmia (change or has loss in smell)
- ☐ Headache
- ☐ Arthralgia (joint pain)
- ☐ Loss of appetite
- ☐ Cough
- ☐ Muscle aches
- ☐ Diarrhoea
- ☐ Nausea and/or vomiting
- ☐ Dysgeusia (change or loss in taste)
- ☐ Rhinorrhoea
- ☐ Fatigue
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Other: .....

3. Are any of the above symptoms related to your reason for admission? ☐ Yes ☐ No

4. Symptom onset date:

Additional information:

5. Has the patient recently been tested for COVID-19? ☐ Yes ☐ No

Date tested:

Test type: ☐ PCR ☐ RAT

COVID-19 test result: ☐ Negative ☐ Positive ☐ Pending

6. Have you/your carer been informed in the past 7 days that you are a close contact of someone who has tested positive for COVID-19?
☐ Yes ☐ No

| Patient/Carer name: | Patient/Carer signature: | Date: |
|---|---|---|
| | | |

## HOSPITAL STAFF USE ONLY

If the person has presented for a direct admission and flags to any of the previous questions please notify the Infection Control Coordinator on 0455 425 302 and/or the After Hours Coordinator on 0437 739 991.

### SAWMH COVID-19 Test

Test type: ☐ PCR ☐ RAT

Result of COVID-19 test: ☐ Negative ☐ Positive ☐ Pending

Please tick below if the patient cleared to progress with admission:

☐ Cleared for entry/admission ☐ NOT cleared for entry/admission

Cleared by: ☐ VMP ☐ After Hours Coordinator ☐ Anaesthetist ☐ Infection Control Coordinator

Additional notes:

| Staff name: | Designation: | Signature: | Date: |
|---|---|---|---|
| | | | |

BINDING MARGIN - DO NOT WRITE.

CORONAVIRUS (COVID-19) SCREENING 181.96