UnitingCare

Coronavirus (COVID-19) Screening

Family Name: _____ MR/UR: _____
Given names: _____
Address: _____
Postcode: _____ DOB: _____
Doctor: _____
(or place Patient ID 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. 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 or Presentation **Date:**____ / ____ / ____

_____

_____

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

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

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 / 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

Please bring this form on your day of admission.

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HOSPITAL STAFF TO COMPLETE	
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.	
COVID-19 Test By SAWMH **Test Type:** ☐ PCR ☐ RAT **COVID-19 Test Result:** ☐ Negative ☐ Positive ☐ Pending	
☐ **Cleared for entry / admission**	**Cleared by:** ☐ VMP ☐ After Hours Coordinator ☐ Anaesthetist ☐ Infection Control Coordinator
Patient Name: _____ **Admission Staff Name** _____ **Patient Signature:** _____ **Admission Staff Signature:** _____ **Date:** ___/___/___ **Date:** ___/___/___	

Additional Notes

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