TRIAGING - COVID RISK ASSESSMENT PRIOR TO CLINIC VISIT

Name:	Age:
Date:	Time:
Address: (from containment zone -Y/N)	Mobile Number:

Please carefully review the following screening questions prior to attending your scheduled appointment. If you must respond yes to any of the following questions, please do not come in for your appointment and contact our office for next steps.

1. Have you been sick in the last two weeks? **Yes** ☐ **No** ☐
2. Have you any travel history in last 14 days **Yes** ☐ **No** ☐

    a. International travel within 14 days **Yes** ☐ **No** ☐
    b. Interstate travel within 14 days **Yes** ☐ **No** ☐
    c. Travel within state within 14 days **Yes** ☐ **No** ☐

3. Do you have any of the following symptoms?

    a. Fever ≥ 100.0° F or 38°C - **Yes** ☐ **No** ☐
    b. Cough or sore throat - **Yes** ☐ **No** ☐
    c. Runny nose - **Yes** ☐ **No** ☐
    d. Shortness of breath - **Yes** ☐ **No** ☐
    e. Muscle aches or headache - **Yes** ☐ **No** ☐
    f. Fatigue - **Yes** ☐ **No** ☐
    g. Nausea, vomiting, diarrhoea, abdominal pain - **Yes** ☐ **No**
    h. Reduced sense of smell - **Yes** ☐ **No** ☐

4. Have you been diagnosed with COVID-19? If yes, please answer these questions:

    a. Do you have documentation of a negative test after illness OR - **Yes** ☐ **No** ☐
    b. Has it been at least 72 hours since your last fever and 7 days since the onset of any symptoms? - **Yes** ☐ **No** ☐

5. Have you had close contact with a person who has tested positive for COVID-19 or is in the process of being tested for COVID-19 in the prior 14 days? **Yes** ☐ **No** ☐

   Close contact includes:

   - Living in the same household as a sick person with COVID-19
   - Caring for a sick person with COVID-19
   - Being within 6 feet of a sick person with COVID-19 for 10 minutes or longer
   - Being in direct contact with secretions from a sick person with COVID-19 (e.g., being coughed on, kissing, sharing utensils, etc.).

6. History of taking paracetamol in the past 7 days. **Yes** ☐ **No** ☐
7. Do you work in a hospital / nursing home or healthcare facility? **Yes** ☐ **No** ☐

   If yes, please answer the following questions:

   a. Have you been exposed to a patient with COVID-19 when you were not wearing a mask? **Yes** ☐ **No** ☐
   b. Have you been exposed to a patient with COVID-19 who was not wearing a mask, when you were wearing a mask, but no eye protection? **Yes** ☐ **No** ☐

8. Do you live in a household with somebody who has been diagnosed with COVID-19 infection or has COVID-19 symptoms (fever, cough, loss of smell)? **Yes** ☐ **No** ☐
9. Do you have a severe medical condition like diabetes, respiratory disease, chronic kidney disease, etc.? **Yes** ☐ **No** ☐

Name: ……

Signature: ……