Patient Questionnaire re COVID-19

Patient's Name: _____

Patient's Address: _____

_____

_____ Postcode: _____

Date of Birth: _____/_____/_____

Questions

1. Have you got a cough, high temperature or shortness of breath now, or have had any time in the past week? Yes / No

2. Have you lost your sense of taste or smell? Yes / No

3. Does anybody in your household have a cough, high temperature, shortness of breath, or have a confirmed, positive test or COVID-19 diagnosis? Yes / No

   If so, who? _____

Patient or person completing the form

Name: _____

Signature: _____ Date: _____/_____/_____

If any answers are "YES" to the questions above, please do NOT proceed with any treatment, and as necessary, refer to the Clinical Lead or Manager.