L Number:
Patient Name:
DOB:
M/F:
Consultant:

CORONAVIRUS SCREENING QUESTIONNAIRE

1. **In the last 14 days have you experienced any flu-like symptoms including a temperature of 37.8°C or higher AND any of the following symptoms suggestive of Coronavirus? YES / NO**

- ☐ New persistent cough (with or without sputum)
- ☐ Difficulty of breathing/ more breathless than usual
- ☐ Nasal discharge or congestion
- ☐ Wheezing
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Sneezing

2. **In the last 14 days have you experienced the loss of, or change in, normal sense of taste or smell? YES / NO**

3. **In the last 14 days have you come in contact with a known or suspected case of Coronavirus? YES / NO**

1. If you answered **YES** to any of the above questions we ask that you please stay at home and self-isolate until you are symptom free for 7 day. If symptoms worsen please call 111 or contact NHS 111 online.

2. If you have completed this form and are already on the Clinic premises, please inform the nearest staff member. We will provide you with a surgical mask and liaise with your consultant.

This form must accompany the patient throughout their Journey within the Clinic

CLINICAL REVIEW SECTION (If required)

Assessor (Print Name):

Date:

Time:

Additional comments: