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PATIENT'S PRE-TREATMENT SCREANING COVID 19 QUESTIONNAIRE

Today's Date:

Patient's Name:
Patient's Date of Birth:

You are considering attending the clinic/doctor for a consultation or a procedure. We want you to be well. We are doing everything we can to keep you safe. This questionnaire is designed for the safety of you and the clinic staff. If you or we think that you have a high chance of currently being infected with coronavirus, you should delay your attendance until a safer time, and we may advise this.

Please answer these questions as honestly as you can:

Question	Answer
Have you been tested for coronavirus?	Y/N
Have you had a fever in the past two weeks?	Y/N
Have you had a cough in the past two weeks?	Y/N
Have you had any other symptoms suggestive of a viral infection within the last two weeks, such as muscle pain, lethargy, diarrhoea or vomiting, or loss of smell?	Y/N
Have you been exposed to anyone who has had COVID-19 in the past one month?	Y/N
Have you travelled outside the UK in the past 14 days and if so, where did you travel?	Y/N

If you answer YES to any of these questions, we will need to contact you in advance of your attendance.