PATIENT QUESTIONNAIRE

COVID19

Please complete the form below with reference to COVID19

CONTACT IN THE LAST FOUR (4) WEEKS

- Have you been in contact with any person diagnosed or suspected of COVID19 infection? Yes/No
- Have you been on a cruise ship? Yes/No
- Have you returned from overseas? Yes/No
- Have you been in any other State or Territory? Yes/No

SYMPTOMS

Are you suffering from any of the following? (Please circle if applicable)

- Cough
- Sore throat
- Decreased taste/smell sensations
- Chills, fevers
- Unusual aches and pains, flu-like symptoms
- Unusual tiredness

DECLARATION

- I declare the above responses are true and correct.

Signature: ..... Name: .....

Date: .....

Email address: ..... Mobile: .....

Contact of nearest relative/friend:

Relationship: ..... Mobile: .....

OFFICE USE

Assessor name: .....

Relative Risk Allocation: