COVID-19
PATIENT PRE-APPOINTMENT CHECK

Please retain in patient file

abdo

PATIENT NAME:

DATE of TELEPHONE CALL:

DATE of APPOINTMENT:

QUESTIONS	YES	NO
Do you have a fever?	☐	☐
Do you have a cough?	☐	☐
Do you have a new loss of taste or smell?	☐	☐

If the answer is **NO** then they should be asked to keep appointment and if they feel unwell at all on the day to contact the practice to cancel.

If the answer is **YES** to any of the questions above the patient should be directed to stay home and self-isolate for 7 days. If they live with others they should stay home and self-isolate for 14 days. After this period they can reschedule their appointment if they are fully recovered.

If the patient is attending with parent/guardian/carer/translator, the accompanying person needs to be asked the same questions. If they answer **YES** an alternative person should be asked to accompany the patient.

QUESTIONS	YES	NO
Do you have chills?	☐	☐
Do you have shortness of breath?	☐	☐
Do you have repeated shaking with chills?	☐	☐
Do you have muscle pain?	☐	☐
Do you have a headache?	☐	☐
Do you have a sore throat?	☐	☐
Do you have vomiting?	☐	☐
Do you have diarrhoea?	☐	☐

If the patient answers **YES** to at least **TWO of these symptoms**, they should be asked to reschedule their appointment for when they are fully recovered.

If the parent/guardian/carer/translator accompanying the patient answers **YES**, an alternative person should be asked to accompany the patient.