Patient Details

Title: Mr / Mrs/ Ms/ Dr / Other _____ Surname:_____ Given Name:_____

Date of Birth: _____/_____/_____

Have you:

- Been overseas, interstate or on a cruise in the last 14 days? YES / NO _____
- Been in close or casual contact with a confirmed case of COVID-19 in the last 14 days? YES/NO
- Been close to or in casual contact with a high-risk person of COVID-19 in the last 14 days? YES/NO
- Attended a gathering of more than 25 people? YES/NO

Do you have the following symptoms? YES/NO

- ☐ Fever
- ☐ Shortness of breath
- ☐ Cough
- ☐ Sore Throat
- ☐ Vomiting
- ☐ Diarrhoea

Have you been recommended to self-isolate or quarantine following advice from

- National or state COVID-19 hotlines Y/N
- A registered medical or nursing practitioner Y/N
- COVID-19 trained health clinic triage staff Y/N

Declaration

I hereby declare that true and accurate information has been given to the best of my knowledge.

Patient's Signature: _____ Date: _____

Form updated 28/03/2020