Screening/Disclosure Form for Patients During Covid-19 Epidemic

Patient Name: _____ **Age:** _____

Mobile Number: _____ **Gender:** M / F

Residential Address (Proof to be Verified): _____

_____

COVID-19 Questionnaire

	YES	NO
Do you have any symptoms of Fever, Cough, Sore throat, Fatigue, Sudden loss of smell/taste anytime during last 21 days ?		
Did you experience any difficulty in breathing anytime during last 21 days ?		
Do you have any exposure to a known or suspected case of Covid-19 patient in last 21 days ?		
Have you visited any other medical facility /hospital in last 21 days ? If yes, for what reason ?		
Are you residing in a locality that has been notified by the government as a covid containment zone ?		
Have you ever been tested for Covid-19 ?If yes, give details		

The above information given by me is true to the best of my knowledge, I fully understand and acknowledge that withholding or mis-representation of any information is highly unethical and against the interest of larger population during this pandemic.

I understand the Covid-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I fully understand and acknowledge that I / my patient may be an asymptomatic carrier of the disease / undiagnosed patient with COVID19. I confirm that it is my / my patient's responsibility to take appropriate precautions and strictly comply with all safety precautions and protocols advised as not doing so may endanger doctors and clinic staff.

I also understand that, due to the contagious nature of the disease, the fact that I could have been in the incubation period and not be aware, and/or characteristics of procedures and being at a clinic despite best disinfection protocols applied, I / my patient could develop an infection later.

In the eventuality of my testing covid positive at a later date, I will not hold the clinic/staff / managementresponsible for it. I hereby knowingly and willingly give consent to have my investigations and treatment completed during the Covid pandemic.

Patient Signature: **Staff Signature:**

Date: