Date:_____ Time:_____ **TBH COVID-19 PRE-SCREENING CHECKLIST** v7:04/04/2020

Name:	**Surname:**	**DOB:**
Contact numbers:	**Email address:**	**Address:**

A. Does patient have an acute <u>respiratory</u> illness with sudden onset with at least one of the following Sx: **Sx start date: _____**

Circle: fever, cough, shortness of breath, sore throat, loss of smell, loss of taste, other: _____

YES

B. Did the patient travel in the past 14 days?

If Yes to TRAVEL:

Return date: _____

Countries/Provinces: _____

_____

NO

C. Did the patient have contact with a confirmed or presumed COVID-19 case in the past 14 days?

If Yes to CONTACT:

Last contact date: _____

Case Name: _____

NO

D. Is the patient a HCW or attended a COVID-19 hospital?

If Yes to HCW:

Last work date: _____

Work Area: _____

YES **NO**

YES

YES

YES

NO

NO

B. Did the patient travel in the past 14 days?

NO

C. Did the patient have contact with a confirmed or presumed COVID-19 case in the past 14 days?

YES

NO

YES

YES

PUI COVID-19 - TEST

HIGH RISK

Self-isolate until date:

_____

PUI COVID-19 - TEST

LOW RISK

Self-isolate until date:

_____

Triage as Usual

Not COVID-19

At Risk of COVID-19

Self-quarantine until date:

_____