# COVID-19 Screening Questionnaire – Day of Consultation

MEG MELBOURNE ENT GROUP

**Patient Name:**_____

**Patient Date of Birth:**_____

**Patient Contact Number:**_____

**Today's Date:**_____

**Please answer ALL of the following questions within 24 hours of your appointment**

| Question | YES | NO |
|---|---|---|
| Do you have a cough? | | |
| Do you have a sore throat? | | |
| Do you have unexplained shortness of breath? | | |
| Do you have a recent loss of your sense of smell and / or taste? | | |
| Have you or anyone in your family had a COVID19 swab in the last 3 days? | | |
| If so, has the result come back POSITIVE? | | |
| Do you work, or do you have any family members who work, in any places that have had a recent COVID19 outbreak? | | |
| Have you travelled overseas in the last 14 days? | | |
| Has your family or household members returned from overseas travel within the last 14 days? | | |
| Have you cared for or come into contact with anyone with a confirmed case of COVID19? | | |

If any of the above questions are answered 'YES' then Bring to attention of Consulting ENT, and then likely proceed with MEG Policy of advice and appointment rescheduling.

This document has been completed by asking the patients the questions and recording the responses as given.

## MEG Staff to complete following questions on arrival to clinic:

| Question | YES | NO | N/A |
|---|---|---|---|
| Passed Thermal Scan | | | |
| Passed Manual Temperature Check (only when Thermal Scan Temp >37.5°C) | | | |

This document is to be scanned/uploaded into the patients file.

If an additional document is filled in by a parent/carer or interpreter it will also be scanned in the attending patients file,