SGO Stiftung – Gesundheitsversorgung – Oberengadin

Covid-19 questionnaire for ambulatory treatments

We are all trying to stem the spread of the Corona virus. To achieve this goal, we ask you to fill out the questionnaire truthfully. We thank you for your valuable support. If there are any changes in your health (after filling in the questionnaire), please let us know immediately.

Name:………………………………………………….**First Name:** ……………………………**Date of birth:** ……………….

Place of the appointment: ……………………………………….…..**Beginning of treatment:** ………………………

Questions about disease symptoms:

Have you had any of the following symptoms within the last 48 hours (2 days)?	Yes	No	If Yes - Date	Comments:
* Cough (usually dry)	❑	❑		
* respiratory symptoms / shortness of breath	❑	❑		
* fever, feverish feeling, muscle aches	❑	❑		
* Headaches	❑	❑		
* Sudden loss of the sense of smell and/or taste	❑	❑		

Questions regarding Covid-19:	Yes	No	If Yes - Date	Result? Positive (Evidence of Covid-19)	Result? Negativ (No evidence of Covid-19)
➢ Are or were you in quarantine or (self) isolation?	❑	❑			
➢ Have you ever been tested with a COVID-19 cervical smear?	❑	❑		❑	❑
➢ Have you ever been tested for COVID-19 antibodies?	❑	❑		❑	❑
➢ Have you already had a computer tomography (CT) of the lungs with the question COVID-19?	❑	❑		❑	❑
➢ Have you had contact with a confirmed or suspected COVID-19 person?	❑	❑		Comments:	
➢ If yes - Close contact? Consider as close contact: Contact of <2m and for >15 minutes, intimate contact, living in the same household, nursing or direct contact with respiratory secretions or body fluids without personal protection measures	❑	❑			

Place / Date: ……………………………………………… Signature: ………………………………………………………….
Patient or relatives

Entscheid durch behandeltes Personal:

- *Wenn Fragen mit Ja beantwortet ➔ abklären ob Behandlung unbedingt erforderlich ist*
- ➢ *Fragen müssen beurteilt werden ➔ anschliessend Massnahmen bestimmen*

Behandlung durchführen: ❑ **Ja** (welche Massnahme sind notwendig) ❑ **Nein**

Keine speziellen Massnahmen notwendig	❑	
Covid-19 Schutzmassnahme	❑	
Behandlung verschieben	❑	
Andere:	❑	

Ort / Datum: ……………………………………………… Unterschrift: ………………………………………………………….
Fragebogen wird eingescannt/in Pat Akte abgelegt Behandeltes Personal

SQS ISO 9001