Declaration/ Screening form For Covid -19 Infection

Name of the Patient :-

Age/ Sex :-

Address :-
an

Mobile No :- E- mail ID:-

Covid – 19 Questionare		YES	NO
1	Do you have symptoms of Fever, Cough, Sneezing, Sore throat ,fatigue,myalgia.		
3	Do you have Difficulty in breathing?		
4	Have you travelled outside the country in past 30 days?		
	If Yes, Mention the Countries		
5	Have you travelled inside India to other cities in past 15 days.		
	If Yes, Mention the Cities		
6	Exposure to a confirmed Covid -19 case OR to Suspicious patient in the last two weeks?		
7	Have you visited a health care facility in the past two weeks ?		

Signature of the Patient :- ……..

The above information is true to the best of my knowledge . I understand that withholding any information is unethical and against the interests of the global population fighting this pandemic.

Staff sign:- …….. Date:- ……..