PSO-HNS COVID-19 SCREENING AND TRIAGING TOOL

Name:	Age / Sex:	Date:
Address:	Contact no.:	
Guardian / Accompanying Person:	Relationship to Patient:	

We would like to ask for your cooperation to fill up this form truthfully.

Questions: Please place a check (✔) in the appropriate column	**YES**	**NO**
1. In the past 14 days, do you have or have had any of the following symptoms?		
FEVER (temp. ≥ 38 ℃)		
COUGH		
COLD (nasal congestion / discharge)		
SORE THROAT		
New onset or worsening shortness of breath		
Body ache / muscle pain		
Headache		
Fatigue		
Diarrhea		
New onset loss or decreased sense of smell and / or taste		
2. In the past 14 days, did you have close contact with any COVID-19 positive/ suspected/ probable cases or people with the previously mentioned symptoms, while not wearing proper protective equipment **(ex. FACE MASK)**?		
3. In the past 14 days, did you travel to or reside in a country with community transmission (e.g. USA, Italy, Germany, Iran, Indonesia) or in local hot zones/areas under enhanced community quarantine (e.g. Metro Manila, Central Luzon, CALABARZON) ***refer to the following websites for updates on community transmission:** https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/; https://ncovtracker.doh.gov.ph/		
Patient's / Guardian's/ Accompanying Person's Signature:		

- If the answer is **YES** to ANY of the questions, refer to the nearest COVID-19 testing facility for further screening, possible testing and appropriate management. Consider offering telemedicine for other ENT concerns.
- If the answer is **NO** to ALL questions, may proceed with consultation either through telemedicine or face-to-face.

SOURCE OF REFERENCE
WEBSITE GOOGLE ADs FACEBOOK Word of mouth (FAMILY / FRIENDS) Others: