Questionnaire for Risk Assessment and Early Detection

Date: ___/___/_____

Name: _____

Address: _____

Personal Contact.: _____ **E-mail:** _____

Date of Birth: ___/___/_____ **Health Number (if available):** _____

EPIDEMIOLOGICAL CRITERIA	RESPONSE	
History of travel or residence in **areas with confirmed cases of COVID-19**, in the last 14 days.	☐ YES	☐ NO
Contact with a confirmed or probable case of infection by SARS-CoV-2 or COVID-19, in the last 14 days.	☐ YES	☐ NO
CLINICAL CRITERIA		
Cough OR **Fever** OR **Shortness of breath**	☐ YES	☐ NO
Test for COVID-19, in the last 72 hours. Test Type: _____ Test Date: __/__/___ Result:_____ Institution where it was held _____	☐ YES	☐ NO
Date of onset of the symptoms	____/____/_____	

Attention:

All persons who develop an acute respiratory syndrome (with persistent or worsening of usual cough) or fever (temperature> 38ºC) or dyspnoea/difficulty breathing should be identified as a suspected case of COVID-19.

The person following the procedures described in the contingency plan of the institution must be immediately isolated, and the emergency response shoud activated (Line SRS24 – 800 24 24 20).

Thanks for the collaboration!

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