Covid-19 Likelihood Assessment

First name: Family name: Date of birth:

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Date: Clinician Name: Signed:

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| ***Symptoms*** | Symptoms | Y/N | When did it start? | Notes |
| Recent fever or shivering |  |  |
| Cough |  |  |
| Sore throat |  |  |
| Shortness of breath |  |  |
| Other symptoms |  |  |
| ***Household*** | How may people live in the house with you?  Are others ill?  How many bedrooms?  How many people sleep in your bedroom? | | |  |
| ***Covid-19*** | Has anyone had or been tested for Covid-19 that you have had contact with?  Details: | | |  |
| ***Travel*** | Where were you 14 days ago?  Where have you travelled since then?  (Please record dates for arrival and departure for each location) | | |  |
| ***Household travel*** | Has anyone in your household arrived back from travel in the past 14 days?  Where did they travel to? | | |  |
| ***Health care worker*** | Do you work with people directly in a health care or aged care setting? | | |  |

**CDC**: 08 8922 8044 after-hours via RDH Switchboard: 08 8922 8888