NORTHERN PAIN CENTRE

PATIENT SCREENING QUESTIONNAIRE FOR COVID-19

This mandatory screening is to protect the health of our patients and Northern Pain Centre Personnel

Please Circle Yes or No

1. **Do you have a fever or Respiratory Symptoms?** **Yes** **No**
   Symptoms include fever OR an acute respiratory infection and include (but are not limited to) cough, sore throat, fatigue and shortness of breath with or without a fever.

2. **Have you been identified as a close contact of a confirmed case of novel coronavirus?** **Yes** **No**
   A close contact is someone who has been face to face for at least 15 minutes, or been in the same closed space for at least 2 hours, as someone who has tested positive for the COVID-19 when that person was infectious.

3. **Have you returned from overseas within the last 14 days?** **Yes** **No**

4. **Are you waiting on COVID-19 swab results?** **Yes** **No**

5. **Have you been asked to self-isolate by your GP, or a government authority?** **Yes** **No**

If you have circled **Yes** to any of these 5 questions you must not enter Northern Pain Centre.

Please use your mobile phone to call 9439 6456 and our admin staff will assist you in rescheduling your appointment.

If you have circled **No** to all of these 5 questions please print your name, date and sign this document before entering the clinic and passing it to our reception staff. Our reception staff will scan this document into your electronic record. Thank you.

I, the undersigned hereby declare that the information I have provided in this questionnaire is true and accurate

Print Full Name_____

Your signature_____ Date__/___/_____