Symptomatic COVID-19 Testing Form

Due to the increased volume of phone and email queries about Coronavirus testing in light of broadening of testing criteria announced by the Health Service - we are now asking symptomatic patients to fill out the following questionnaire to help us assess you more efficiently.

We understand our patients are concerned for themselves and their loved ones and we can assure you we are doing everything we can to operate as normally as possible in these extraordinary times, while at the same time minimising the risk of exposure to our patients or indeed our practice.

Please fill out the below form to help us triage your symptoms to see if you need testing for Covid-19

FIRST NAME *

LAST NAME *

PPSN*

MOBILE PHONE NUMBER *

EMAIL *

DATE OF BIRTH *

dd/mm/aaaa

ADDRESS 1 *

ADDRESS 2

CITY *

COUNTY *

COUNTRY *

SYMPTOMS

Please outline your symptoms below:

- [ ] Fever
- [ ] Cough
- [ ] Shortness of Breath
- [ ] Sore throat
- [ ] Runny nose
- [ ] Diarrhoea
- [ ] Aches & Pains
- [ ] Vomiting
- [ ] Fatigue
- [ ] Sudden loss of sense of smell
- [ ] Headache
- [ ] No symptoms

DURATION OF SYMPTOMS *

When did you start displaying symptoms?

SEVERITY OF SYMPTOMS *

How severe are your symptoms?

ARE YOU CURRENTLY SELF ISOLATING? *

Anybody with respiratory symptoms of any kind is now advised to self-isolate.

CORONAVIRUS CONTACT *

Have you been in close contact with a confirmed coronavirus case?

NEW OR EXISTING PATIENT *

Are you an existing patient of this practice or are you a new patient

HEALTHCARE WORKER *

Are you a healthcare worker with patient-facing contact?

ARE YOU IN AN AT RISK GROUP? *

History of ischaemic heart disease, high blood pressure, history of Stroke/ TIA, Type II diabetes, obesity, active malignancy in last 5 years, chronic lung disease, chronic renal disease, chronic liver disease.

ARE YOU A HOUSEHOLD CONTACT OF AN AT-RISK GROUP? *

DO YOU WORK IN THE PRISON SERVICE? *

ARE YOU CURRENTLY PREGNANT? *

ARE YOU A STAFF OR RESIDENT IN A LONG-TERM CARE FACILITY OR NURSING HOME? *

BRIEF OUTLINE OF YOUR SYMPTOMS/CONCERNS *

Please give a brief outline of your symptoms, when they started and your concern re testing. If you have any other symptoms not covered in the checklist above, please let us know here also.