

Short screening
during the covid-19 pandemic

Akademisches Lehrkrankenhaus
der Universität Duisburg-Essen

General information about yourself (Information as in the official identification document)

First name and surname: _____

Address: _____

Phone number: _____

Patient to be visited: _____

Patient room number: _____

Date _____ Time of receipt _____ Time of exit _____

Information about any cold symptoms

Have you had any of the following symptoms in the past 14 days

- | | | |
|---|------------------------------|-----------------------------|
| ▶ fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▶ sore throat and / or difficulty swallowing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▶ cough | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▶ shortness of breath | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▶ loss of taste or smell | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▶ general fatigue and / or loss of performance, unless it can be explained by existing medical conditions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▶ (for example allergy) explainable | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| ▶ have you had contact with a SARS-CoV-2 positive person within the last 14 days? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Is filled in by the Marienhospital:

Instruction in the hygiene measures has been given YES NO

Admission of the visitor was granted YES NO

Date, Signature of the visitor

Date, Signature of the institution

Please fill out the form in the ambulance and discuss any symptoms with the staff.
Do not return the form to the ambulance staff until you leave the children's clinic. Many thanks