Declaration/Screening form For COVID-19 Infection

Date:

Name of the Patient: Age/Sex: Contact no:

Address: Email ID:

COVID 19 Questionnaire			
1	Do you have symptoms of Fever, Cough, Sneezing, Sore throat, Fatigue, Myalgia?	YES	NO
2	Do you have difficulty in breathing?	YES	NO
3	Have you travelled outside the country in past 30 days?	YES	NO
If Yes, Mention the countries.			
4	Have you travelled inside India to other cities in past 15 days?	YES	NO
If Yes, Mention the cities.			
5	Exposure to a confirmed COVID-19 case OR to Suspicious patient in last two weeks?	YES	NO
6	Have you visited a health care facility in the past two weeks?	YES	NO

The above information is true to the best of my knowledge. I understand that withholding/concealing the above information is unethical and against the interests of the global population fighting the COVID 19 pandemic.

During this lockdown in the wake of the current COVID 19 pandemic, I have come to the hospital by myself voluntarily to avail Emergency Treatment/ Treatment. If I am an asymptomatic carrier or an undiagnosed patient with COVID 19, I suspect it may endanger doctors and hospital staff, and therefore, it is my responsibility to take appropriate precautions and to follow the protocols prescribed by Government of India and other healthcare institutions.

Despite all efforts taken by Hospital/Doctors/staff of Doctors to prevent COVID 19 which is explained to me, I understand that I may get an infection from the hospital or from a doctor, and I will take all precautions to prevent this from happening, but I will not at hold doctors and hospital staff accountable if such infection occurs to me or my accompanying persons.

If I hide my facts and relevant details and because of my intentional or unintentional behaviour or action OR If any Healthcare personnel gets infected, I will be held responsible and appropriate legal actions shall be taken against me and my attendant.

Patient's Sign/Thumb impression:

Details of Patient's Attendant	Details of Hospital Staff
Name & Signature	Name & Signature
Relationship with Patient	Employee ID
Address & Phone Number	