Greenlane Medical Specialists

PATIENT HEALTH DECLARATION FORM (COVID-19)

Patient Details			
Full Name:			
NHI Number:		Date of Birth:	
Full Residential Address:			
Contact Number:			
Email:			

Health Declaration Questions - *please tick all that apply*

☐ Have you returned from overseas within the last 14 days?

☐ Have you been in contact with anyone with suspected COVID-19?

☐ Do you have the following symptoms?

- ☐ Fever T > 37.5°C
- ☐ Cough and shortness of breath
- ☐ Diarrhoea less than 7 days

What is your most recent temperature? - *Please specify*

Patient Declaration

I hereby declare that the information I have disclosed is true and complete.

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

Temperature taken at the Clinic:

DATE: _____

GLMS STAMP: