Absolute Dental

Covid-19 Triage Form

First name _____

Last name _____

Date of Birth: _____

Address: _____

_____

Phone No: **Home** _____ **Mobile** _____

Do you have a confirmed diagnosis of COVID-19?
Yes No

Are you waiting for a COVID-19 test?
Yes No

Are you awaiting the results of a COVID-19 test?
Yes No

Have you returned from overseas travel in the last 14 days?
Yes No

Have you had contact with someone with a confirmed diagnosis of COVID 19, or been in isolation with a suspected case in the last 14 days?
Yes No

Do you have any of the following symptoms?
Yes No

	Yes	**No**
Cough		
Sore Throat		
Fever		
Shortness of Breath		
Running Nose		
Sneezing		
Post-nasal drip		

Loss of Smell		
Loss of Taste		

Form filled and submitted by

	Signature
Parent	
Guardian	
Patient	

Date: