INFECTION PREVENTION AND CONTROL IN THE GJ-TCM CLINIC CENTRE

Triage Questionnaire for Infection prevention and control screening

Name:________________________Date:__________Time:_______

Are you experiencing any of the following symptoms?

1. Muscle aches.. No Yes
2. Severe fatigue, feeling unwell...No Yes
3. Severe headache (worse than usual)..No Yes
4. New or worsening cough...No Yes
5. Shortness of breath (worse than is normal for you) ....No Yes
6. Feeling feverish or have had a fever in the last 24 hours...............................No Yes
7. New rash associated with fever.. No Yes
8. Have you recently travelled or been in contact with a sick person that has travelled in the last 14 days? ....No Yes

If you answer "yes" to any of the above questions, please call us BEFORE Booking. You may be arranged a specific time of the appointment, when you arrive, please notify receptionist you will be placed in a private exam room and health care providers may wear a mask.