Please do not arrive earlier **than 15 minutes before a scheduled appointment**. Please fill out the questionnaire carefully on the day of the treatment / appointment and show it to our staff at the "Karls Cafe" / at the gate or in the central patient admission.

Please check: [ ]  Patient [ ]  Companion

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name, First Name: |       |  | Date of birth: |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Address: |       |  | Phone number: |       |
|  |  |
| For patients: Name of the clinic / department: |       |
| For companions: Name, first name of the patient: |       |
| Appointment date: |    |  | time of day: |        |

**Proof:** [ ]  Negative corona test (< 48 h) [ ]  Complete vaccination (2nd dose> 14/28 d) [ ]  Recoverd

|  |  |  |
| --- | --- | --- |
| **If none of the three certificates is available, please fill in carefully:** | **No** | **Yes** |
| Have you been abroad / at risk in the last 14 days? | [ ]  | [ ]  |
| In the last 14 days, have you had contact (> 10 minutes, > 1.5 meters distance) with someone who can be proven to have COVID-19? | [ ]  | [ ]  |
| Have you had a corona smear taken? |  |  |
| If so: Date:  | [ ]  | [ ]  |
|  Test result: [ ]  positive [ ]  negative [ ]  Result open |  |  |

|  |  |  |
| --- | --- | --- |
| **Do you have the following symptoms?** | **No** | **Yes\*** |
| Loss of taste and/or smell | [ ]  | [ ]  |
| Fever >37,5° Celsius | [ ]  | [ ]  |
| Dry Cough | [ ]  | [ ]  |
| Muscle-, joint pain and/or headache | [ ]  | [x]  |
| Sore throat | [ ]  | [ ]  |
| Feeling exhausted/severe feeling of illness | [ ]  | [ ]  |
| Nausea/vomiting/diarrhoea | [ ]  | [ ]  |
| Sniff | [ ]  | [ ]  |
| Shortness of breath | [ ]  | [ ]  |

The information is subject to medical confidentiality and data protection regulations and is treated as strictly confidential. \*Medical assessment required

|  |
| --- |
| **Medical assessment:** **Suspected COVID □ Yes □ No**If yes, contact the clinic directly to clarify:□ Send the patient back to the referring physician / general practitioner**Comment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_ Signature of the doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I will notify you immediately of all changes regarding the named COVID symptoms that occur during the entire treatment period.

**I will adhere to the following rules, please check:**

|  |  |
| --- | --- |
| Wear mouth-nose protection during your stay | [ ]  |
| Keep a distance from other people (at least 1,5 m) | [ ]   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date: |   |  | Signature of patient, accompanying person: |  |

[ ]  Identity verified / admission granted Signature RMK / Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_