**Centre For Sleep COVID Screening Questionairre**

**Patient Name: CRN:**  **Date:**

If no to all questions proceede to inviting the patient to their sleep sudy later today

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| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
| 1) | Do you or any member of your household/family have a confirmed diagnosis of COVID-19? If yes rebook after the agreed period of time |  |  |
| 2) | Are you or any member of your family awaiting a COVID-19 test result?If yes rebook after the agreed period of time |  |  |
| 3) | Have you been in contact with anyone with a confirmed case of COVID-19 in the last 14 days?If yes rebook after the period of self isolation |  |  |
| 4) | Have you traveled internationally in the last 14 days?If Yes, is the destination on the self isolation list? If Yes rebook for after 14 days since return |  |  |
| 5) | Have you traveled to a area in local lockdown in the last 14 days? If Yes rebook for after 14 days since return |  |  |
| 6) | Do you have a high temperature/fever? (>37.8) |  |  |
| 7) | Do you have a new or continious cough? |  |  |
| 8) | Have you had or loss or alteration of your taste or sense smell? |  |  |
| 9) | Do you need assistance with walking? |  |  |
| 10) | Do you need any help with activities of daily living |  |  |
| 11) | Do you use CPAP or a ventilator? |  |  |
| 12) | Do you use oxygen? |  |  |
| 13) | Do you use a nebuliser? |  |  |
| 14) | Do you smoke?If the patient answes yes please remind them that they cannot go out to smoke and if this is not possible for them they will need to be rebooked |  |  |
| 15) | Do you have any dietry requirments? If so what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Signed:**   **Date:**