**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:**