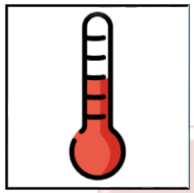
Participant COVID-19 screening

CONTACT

- Contact with a *confirmed or suspected* COVID-19 case within the last 14 days
- Healthcare, aged, or residential care worker involved in direct patient care

TRAVEL

- *International travel* within the past 14 days
- Known *contact* with someone who has returned from *international travel* in the last 14 days?



SYMPTOMS

- Experienced *one or more* of the following in the last 14 days:
  - Fever or chills
  - Cough
  - Fatigue
  - Shortness of breath
  - Muscle or joint pains
  - Headache
  - Sore throat
  - Blocked nose
  - Nausea and vomiting
  - Diarrhoea

Reference: Australian Government Department of Health; Coronavirus disease (COVID-19). Guidance for symptom monitoring in health and aged care workers during the COVID-19 outbreak

COVID-19 screening assessment

Study: _____

Participant code: _____

Date: _____

DAY PRIOR TO VISIT Researcher/assessor: _____

CONTACT			
Have you been in contact with a *confirmed or suspected* (being tested) case within the past 14 days?	☐ YES	☐ NO	If yes, date:
Have you been in contact with *someone who has returned from overseas* in the past 14 days?	☐ YES	☐ NO	If yes, date:
TRAVEL			
Have you been on a *cruise ship* in the last 14 days?	☐ YES	☐ NO	If yes, date:
Have you arrived from *overseas* in the last 14 days?	☐ YES	☐ NO	If yes, date:
Have you arrived from *interstate* in the last 14 days?	☐ YES	☐ NO	If yes, date:

SYMPTOMS			
Do you feel unwell with <u>*any*</u> *cold or flu like symptoms* such as cough, sore throat, headache, fatigue or body aches?	☐ YES	☐ NO	If yes; describe: _____ _____ _____
Do you/have you *felt feverish*, had night sweats or had a high temperature recorded recently?	☐ YES	☐ NO	If yes; describe: _____ _____

OUTCOME

☐ Continue with participation/testing ☐ Pause participation & reassess [date]: _____

NOTES:_____

DAY OF VISIT Researcher/assessor: _____

CONTACT			
Have there been any changes in contact with a confirmed or suspected case or overseas travers since the previous assessment?	☐ YES	☐ NO	If yes; describe: _____ _____
SYMPTOMS			
Do you feel unwell with <u>*any*</u> *cold or flu like symptoms* such as cough, sore throat, headache, fatigue or body aches?	☐ YES	☐ NO	If yes; describe: _____ _____ _____
Do you/have you *felt feverish*, had night sweats or had a high temperature recorded recently?	☐ YES	☐ NO	If yes; describe: _____ _____

OUTCOME

☐ Continue with participation/testing ☐ Pause participation & reassess [date]: _____

NOTES:_____

Reference: Australian Government Department of Health; Coronavirus disease (COVID-19). Guidance for symptom monitoring in health and aged care workers during the COVID-19 outbreak