Saint John of God Hospital

Covid-19 Screening Questionnaire

As per the following protocols, all patients admitted to Saint John of God Hospital must be screened for Covid-19. This applies to Walk-in Assessment Protocol, Protocol for Transfer/Admission from another facility (i.e. Healthcare, Prisons) and the Admission Protocol.

Patient Details	
Patient Name: Or insert Date of Birth: Patient Label MHIS No:	
Patient Mobile No:	Accompanying Persons Mobile No:

Screening Questions	**Answer**
1. Have you been diagnosed with confirmed or suspected Covid-19 infection in the last 14 days?	Yes ☐ No ☐
2. Are you currently experiencing any of the following symptoms (*Guidance to clinicians – please consider if there is a known aetiology)*: ○ Cough / Shortness of breath / Breathing difficulties ○ Loss of Sense of Smell / Taste ○ Distortion of Sense of Taste ○ Fever (high temperature) ○ Sore throat ○ Runny nose	Yes ☐ No ☐
3. Are you a contact of a person who is confirmed or suspected of Covid-19 or have you been advised to self-isolate in the last 14 days (17 days for contact with a confirmed case of Covid-19 in a child)?	Yes ☐ No ☐
4. Have you or a member of your household travelled internationally in the last 14 days? Date of travel: __/___/___ ***Please note a negative PCR test within 72hrs of this travel should be provided.***	Yes ☐ No ☐
5. Have you resided in another facility within the last 14 days? **If yes, please provide the date:** __/___/___ *Guidance to clinicians – please ask if the individual was resident in an area with confirmed/ suspected Covid-19.* ***Please refer to the Covid-19 Transfer Protocol***	Yes ☐ No ☐
6. Have you tested positive for Covid 19 in the last 9 months? **If yes, on what date did you test positive:** __/___/___	Yes ☐ No ☐
7. Have you received a vaccination for Covid-19? **If yes, have received:** Dose 1 ☐ Date: __/___/___ Dose 2 ☐ Date: __/___/___ **Vaccine:** Pfizer/BioNTech ☐ Moderna ☐ Janssen ☐ AstraZeneca ☐ **Booster:** Date: __/___/___ Pfizer/BioNTech ☐ Moderna ☐ ***Please tell the individual to bring their EU Digital COVID Certificate with them as it will be verified on arrival***	Yes ☐ No ☐
8. If you are not vaccinated, would you like a vaccination for Covid-19? **If yes, please email Ms Geraldine Corr the patients details**	Yes ☐ No ☐

Please indicate if the individual has been informed of the following:	
Requirement for negative PCR test result on admission (where possible)	Yes ☐ No ☐
Current Testing Requirements on admission	Yes ☐ No ☐
Current visiting arrangements	Yes ☐ No ☐
Current requirements to bring and wear a face coverings (i.e. cloth mask)	Yes ☐ No ☐
Current leave arrangements	Yes ☐ No ☐
Current isolation requirements (i.e. where the individual is deemed high risk)	Yes ☐ No ☐
Completed By:	
Print Name:	
Signature:	
Date:	
Digital Covid Cert verified at https://app.digitalcovidcertchecker.gov.ie/	Yes ☐ No ☐