Covid19 Questionnaire

If you have decided that a patient has eye symptoms that warrant assessment face to face, before booking an appointment, please ask them all the following questions.

- If they decline to answer, then you may refuse to see them.
- The safety of all the staff is paramount.
- If they answer yes to any of the below, it is advisable not to see the patient face to face. If you feel that they do have symptoms of Covid19 and have a sight threatening condition, please contact your local eye department via email/ telephone who will advise accordingly. Details of all emergency contact details are available on the website at http://essex-loc.org/ see referral pathways or coronavirus.

Please answer yes or no to the following questions, even if mild.

1. Do you have any of the following symptoms of Covid19?

Symptom	Yes	No
Dry cough	☐	☐
Fever	☐	☐
Sore throat	☐	☐
Tiredness	☐	☐
Headache	☐	☐
Muscle aches	☐	☐
Flu like symptoms	☐	☐
Nausea and diarrhoea	☐	☐
Shortness of breath	☐	☐
Any loss of sense of smell and/or taste	☐	☐

2. When did the symptoms start?

_____

_____

3. Are you currently self-isolating?

Yes ☐ No ☐

4. If yes, how long have you been isolating for?

_____

_____

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5. Does anyone in your close family (same household) have any of the following symptoms?

Symptom	Yes	No
Dry cough	☐	☐
Fever	☐	☐
Sore throat	☐	☐
Tiredness	☐	☐
Headache	☐	☐
Muscle aches	☐	☐
Flu like symptoms	☐	☐
Nausea and diarrhoea	☐	☐
Shortness of breath	☐	☐
Any loss of sense of smell and/or taste	☐	☐

6. Has anyone who you have been in close contact with in the last 7days had symptoms?

Yes ☐ No ☐

7. Do you fall into any of the vulnerable categories? E.g. Elderly with co-morbid conditions.

_____

_____

8. If you do not have any symptoms of Covid19, is there any reason why you cannot stay at home?

Key worker ☐ Caring for a vulnerable person ☐

I agree that the information that I have given above is correct and I am aware that by having examinations on my eyes, the Optometrist will be within 1m of me, and unable to safely social distance.

Signature: _____ Date _____

For office use only

Patient surname _____

NHS number if known _____

DOB _____

Post Code _____