RSDC
Respiratory Sleep Disorder Centre

Patient name:

Date of Birth:

CoVID-19 Form

Do you have a fever, cough, SOB, sore throat or runny nose?

Do you have cold/flu symptoms? Or been in contact with anyone who has cold/flu symptoms?

Have you been overseas in the last 14 days, or have you been in contact with anyone who has been overseas in the last 14 days?

I agree that I have answered these questions to the best of my ability

Signature: