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COVID-19 SCREENING TOOL / CONTACT TRACING

Participants details

Full Name: _____

Address: _____

Phone number: _____

Emergency contact number: _____

Current Covid-19 status: Circle Yes/No

Have they been in close contact with a confirmed case of Covid-19 in the last 2 weeks? Yes / No

Have you been referred for or awaiting test results for Covid-19? Yes / No

If tests were carried out please detail result: Yes / No

Are you isolating at present? Yes / No

Do you have any of the following COVID-19 symptoms

- | | |
|--|----------|
| • Cough | Yes / No |
| • Shortness of breath/increased work of breathing | Yes / No |
| • Fever | Yes / No |
| • Fatigue | Yes / No |
| • Sore throat | Yes / No |
| • Abdominal cramping/diarrhea within the last 24 hours | Yes / No |
| • Loss of taste and smell | Yes / No |

On arrival your temperature will be taken with an infrared thermometer, the reading must be logged here:

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Full signature required: _____

Date: _____