

Covid-19 Visitor Form

Dear visitor

Due to the current Covid-19 pandemic it is necessary that all visitors provide some disclosures about themselves in advance. This will assure you, our patients and our employees that further spread of the virus will be avoided.

We are orienting our actions in this connection on the order enacted by the Senatorial authorities for the prevention of new infections, section 14 (1) 1-11, of 3 April 2020.

Thank you for your cooperation and support.

(Please submit photographic identification to verify your data.)

VISITOR DATA

Date of the visit:

Surname, first name:

Date of birth:

Address (address, post code, town/city):

Telephone:

Surname, first name of the patient visited:

Ward:

Please also answer the following questions:

	Yes	No
Have you had any contact with a person who is ill with Covid-19 in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently have or have you had in the last few days any signs of a cold or a flu-like infection with one of the following symptoms, such as a cough, fever, sore throat, fatigue, headaches or aches and pains in your limbs?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently suffering from any loss of your sense of smell and/or taste?	<input type="checkbox"/>	<input type="checkbox"/>
Temperature measurement: degrees Celsius		

- I undertake to observe and comply with the applicable hygiene rules (covering the nose and mouth, disinfecting my hands, minimum distance rules, avoiding any physical contact).
- I give my consent that my data will be stored and may be transmitted to the local authority within the scope of tracking and tracing contact persons.

Date and signature visitor

Date and signature reception employee