

Questionnaire outpatients

PERSONAL INFORMATION

Name, First Name.....

birth date

address

.....

Phone-number. or email-adress:

CONTROL 3G

Did you contract COVID-19 less than 6 months ago and have you recovered?

☐ YES

☐ NO

Have you been completely vaccinated against COVID-19 more than 14 days ago?

☐ YES

☐ NO

Did you test negative for COVID-19 less than 24 hours (rapid antigen test) or less than 48 hours (PCR test)?

☐ YES

☐ NO

If you were able to answer a question with YES, please have the relevant evidence ready for checking!

**If you could not answer any of the questions with YES,
please get tested for SARS-CoV-2 in the test center on the premises.**

SELF-INFORMATION

1) Do you currently have acute cold symptoms of any severity with or without fever and / or loss of smell / taste?

☐ YES

☐ NO

2) Are you in quarantine due to your stay in a COVID-19 risk area?

☐ YES

☐ NO

3) Are you in a quarantine ordered by the health department?

☐ YES

☐ NO

If you answered YES to any of the statements, please contact the receiving employee directly.

date, signature