

Questionnaire stationary patient

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!

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) Have you had unprotected contact with a confirmed COVID-19 case within the past 14 days?

YES

NO

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

date, signature