**PSO-HNS COVID-19 SCREENING AND TRIAGING TOOL**

| Name: | Age/Sex: | | Date: |
|---|---|---|---|
| Address: | | | Phone: |
| Guardian/Accompanying Person: | | Relationship to Patient: | |

**We would like to ask for your cooperation to fill up this form truthfully.**

| **Questions:** Please place a check (✓) in the appropriate column | **Yes** | **No** |
|---|---|---|
| 1. In the past 14 days, do you have or have had any of the following symptoms? | | |
| Fever (temp >38$^0$C)  | | |
| Cough  | | |
| New onset or worsening shortness of breath  | | |
| Cold (nasal congestion/discharge)  | | |
| Sore throat  | | |
| Body ache/muscle pain  | | |
| Headache  | | |
| Fatigue  | | |
| Diarrhea  | | |
| New onset loss or decreased sense of smell and/or taste  | | |
| 2. In the past 14 days, did you have close contact with any COVID-19 positive/suspected/probable cases or people with the previously mentioned symptoms, while not wearing proper protective equipment (ex. face mask)?  | | |
| 3. In the past 14 days, did you travel to or reside in a country with community transmission (e.g. USA, Italy, Germany, Iran, Indonesia) or in local hot zones/areas under enhanced community quarantine (e.g. Metro Manila, Central Luzon, CALABARZON) *refer to the following websites for updates on community transmission: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/; https://ncovtracker.doh.gov.ph/  | | |
| Patient's/Guardian's/Accompanying Person's Signature: | | |

- If the answer is YES to ANY of the questions, refer to the nearest COVID-19 testing facility for further screening, possible testing and appropriate management. Consider offering telemedicine for other ENT concerns.
- If the answer is NO to ALL questions, may proceed with consultation either through telemedicine or face-to-face