Self Screening Tool - Acute Respiratory Illness Screening Questionnaire

Name: _____

Date: _____

Time: _____

1. Do you have new/worse cough or shortness of breath?
   □ Yes
   □ No

2. Are you feeling feverish, do you have shakes or chills in the last 24 hours?
   □ Yes
   □ No

If "yes" please do not visit your loved one for 14 days.

3. Is any of the following true?
   Have you travelled within the last 14 days?
   □ Yes
   □ No
   Where? _____

   Have you had contact in the last 14 days with a sick person who has travelled?
   □ Yes
   □ No
   Where? _____

Please hand into the front office for audit.
If you are in doubt about any of these answers to these questions, please wear the masks provided during your visit or reconsider visiting until another time.

Thank you for your patience while we ensure the safety and good health of your loved ones and our staff.