AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai | COUNTIES MANUKAU HEALTH | Waitematā District Health Board Best Care for Everyone

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

Covid-19 Testing Only Centre Patient Registration and Assessment

COVID-19 TESTING ONLY CENTRE PATIENT REGISTRATION AND ASSESSMENT

Date: ____/____/_____ NHI: _____

FAMILY NAME	GIVEN NAME(S)	PREFERRED NAME
PREVIOUS FAMILY NAME	ALSO KNOWN AS	

GENDER: ☐ Male ☐ Female ☐ Gender diverse OR ☐ Please specify _____ Title *(e.g. Mr/Mrs)*_____

Date of Birth NZ Resident? ☐ Yes / ☐ No *(specify)* ☐ Visitor ☐ Student ☐ Work Visa

ADDRESS Permanent:

Temporary:
(NZ Address)

PHONE Home: Cell Phone:

Work: Temporary number:

PATIENT E-MAIL ADDRESS FOR RECEIPT OF CLINICAL CORRESPONDENCE (PLEASE PRINT CLEARLY)

FAMILY DOCTOR Name: Practice:

Do you consent for your assessment and results to be shared with the above Family Doctor? ☐ Yes ☐ No

ETHNIC GROUP: Tick as many boxes as you need to show which ethnic groups you belong to:

☐ NZ European	☐ Maori	☐ Tongan	☐ Chinese	☐ Other (such as Dutch, Japanese, Tokelauan)
☐ Cook Island Maori	☐ Samoan	☐ Niuean	☐ Indian	**Please state:**

Do you require an interpreter? ☐ Yes ☐ No If yes, please specify language:

TRIAGE

Do you have any acute respiratory infection with at least one of the following: **(please circle)** cough, sore throat, shortness of breath, coryza, anosmia, with or without fever ☐ Yes ☐ No

OR if a high degree of clinical suspicion, such as only: (please circle) fever, diarrhoea, headache, myalgia, nausea/vomiting or confusion/irritability **WITH** no other likely diagnosis **AND** they have a link to a recent traveller, a confirmed or probable case ☐ Yes ☐ No

*If yes to either, this is a **suspected case** and the patient should have a **swab***
***OR** if requested from by local medical officer of health*
*If no, this is a **asymptomatic** person who does **not** require a swab*

Date of symptom onset ____/____/_____

On a scale 0 (no symptoms) to 10 (requiring hospitalisation), how unwell do you feel? ____out of 10

Have you been referred by your ☐ GP ☐ ARPHS ☐ Healthline ☐ ED ☐ Self-referral

CONTACT HISTORY & PRIORITY GROUPS

Have you travelled overseas in the last 14 days? Or have you had contact, in the last 14 days, with someone else who has recently travelled overseas? ☐ Yes ☐ No

Date of travel (date returned to NZ) ____/____/_____

Have you had close contact with a suspected or probable case? ☐ Yes ☐ No

Are you a healthcare worker or essential worker or work in a healthcare facility? i.e hospital, aged residential care, community care, CBAC etc. ☐ Yes ☐ No

If yes, do you **work** as a ☐ DHB employee (☐ NDHB ☐ ADHB ☐ WDHB ☐ CMDHB)
☐ Aged residential care ☐ Primary Care ☐ CBAC ☐ Other (please specify) _____

If not, are you an essential worker? e.g. Prison worker, Firefighter, Rescue ☐ Yes ☐ No

Name and Address of work:

What is your role:

Do you **live** in a vulnerable communal environment: ☐ Aged residential care ☐ Shelter
☐ Barracks ☐ Prison ☐ Large extended family ☐ Other: _____ ☐ Yes ☐ No

COVID-19 PATIENT REGISTRATION AND ASSESSMENT

DD3355

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Swab Taken *(If yes, specimen is sent to LabTests, notify GP and complete eNotification)*	☐ Yes	☐ No
Further Assessment Required *By on-Site by GP or Nurse Practitioner*	☐ Yes	☐ No
Hospital Level Care Required *If yes, swab not required prior to referral to Hospital*	☐ Yes	☐ No

Ensure patient is logged in PMS, label printed, LabTests form completed, swab labelled and NHI allocated

Name: _____ Sign: _____ Designation: _____

TESTING AND ASSESSMENT NOTES