Please do not arrive earlier **than 15 minutes before a scheduled appointment**. Please fill out the questionnaire carefully on the day of the treatment / appointment and show it to our staff at the "Karls Cafe" / at the gate or in the central patient admission.

Please check:  Patient  Companion

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name, First Name: |  |  | Date of birth: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address: |  | | |  | Phone number: | |  | |
|  | | |  | | | | |
| For patients: Name of the clinic / department: | | |  | | | | |
| For companions: Name, first name of the patient: | | |  | | | | |
| Appointment date: | |  | |  | time of day: |  | | |

**Proof:**  Negative corona test (< 48 h)  Complete vaccination (2nd dose> 14/28 d)  Recoverd

|  |  |  |
| --- | --- | --- |
| **If none of the three certificates is available, please fill in carefully:** | **No** | **Yes** |
| Have you been abroad / at risk in the last 14 days? |  |  |
| In the last 14 days, have you had contact (> 10 minutes, > 1.5 meters distance) with someone who can be proven to have COVID-19? |  |  |
| Have you had a corona smear taken? |  |  |
| If so: Date: |  |  |
| Test result:  positive  negative  Result open |  |  |

|  |  |  |
| --- | --- | --- |
| **Do you have the following symptoms?** | **No** | **Yes\*** |
| Loss of taste and/or smell |  |  |
| Fever >37,5° Celsius |  |  |
| Dry Cough |  |  |
| Muscle-, joint pain and/or headache |  |  |
| Sore throat |  |  |
| Feeling exhausted/severe feeling of illness |  |  |
| Nausea/vomiting/diarrhoea |  |  |
| Sniff |  |  |
| Shortness of breath |  |  |

The information is subject to medical confidentiality and data protection regulations and is treated as strictly confidential. \*Medical assessment required

|  |
| --- |
| **Medical assessment:** **Suspected COVID □ Yes □ No**  If yes, contact the clinic directly to clarify:  □ Send the patient back to the referring physician / general practitioner  **Comment:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_ Signature of the doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I will notify you immediately of all changes regarding the named COVID symptoms that occur during the entire treatment period.

**I will adhere to the following rules, please check:**

|  |  |
| --- | --- |
| Wear mouth-nose protection during your stay |  |
| Keep a distance from other people (at least 1,5 m) |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date: |  |  | Signature of patient, accompanying person: |  |

Identity verified / admission granted Signature RMK / Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_