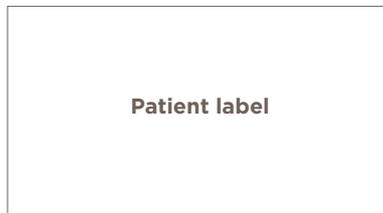




BC_1-3 Patientenadmin. - Eintritt



ST_5 - Eintrittsformular



Patient label

QUESTIONNAIRE COVID-19**Patient**

Last name/first name:

Date of birth:

Gender: f m

Street:

Postal Code/City:

Canton:

Mobile phone:

Internal telephone, if available:

Email:

Healthcare worker: Yes Noif yes: internal externalNationality: CH other

Residence, if not CH:

Occupation:

Employer address:

Health insurance:

 Basic Semi-private Private

Insurance no:

AHV number:

Diagnosis and manifestation

Onset of symptoms:

Symptoms: Fever > 38°C Cough Difficulty breathing Headache Chest pain Sore throat Gastrointestinal complaints Loss of smell Loss of taste Muscle pain Skin rashes Acute confusion or deterioration of the general condition in seniors No symptoms Other symptoms:**Underlying diseases:** Diabetes Cardiovascular disease Immunosuppression Chronic kidney disease High blood pressure Cancer Chronic respiratory disease Overweight (BMI > 35) None Smoker Pregnant Other:**Cost coverage:** Self-payer (travel test) The federal government will assume the costs in accordance with the Covid-19 regulation**Telephone advice in the event of a positive test result:**

If you are found to have the coronavirus, you will be contacted for a short telephone consultation by one of our employees from the Infectious Diseases / Internal Medicine team. This telephone consultation is not covered by the federal government, but is billed through your health insurance company/franchise.

Would you like a telephone consultation?Yes No

Date:

Signature:

To be completed by the test centre staff:**Reason for the test:** Covid-19 smear test due to symptoms of disease Covid-19 rapid antigen test, without symptoms (free of charge) Covid-19 smear test for the purposes of travel (self-payer) Covid-19 smear for the purposes of shortening quarantine Covid-19 smear due to SwissCovid app/cantonal doctor PCR test antigen test

O2 saturation: