MAKATI MEDICAL CENTER

COMPANION'S HEALTH SCREENING FORM

Makati Medical Center ensures the safety of its patients, visitors, employees, medical staff and the community through COVID-19 related disease surveillance. MMC upholds the implementation of patient's and visitor's data privacy rights in accordance with the Data Privacy Act.

The personal data collected in this form is used for the purpose of contact tracing to control COVID-19 transmission. All information are properly secured and retained in Makati Medical Center and will be destroyed after 30 days from the date of accomplishment, following the National Archives of the Philippines Protocol. By filling out the fields below, you consent to the processing of your information as indicated in the Joint Memorandum 20-04 Series of 2020 DTI and DOLE Supplemental Guidelines on Workplace Prevention and Control of COVID-19. Please fill-out the form and present the Companion's Screening Report to the healthcare provider. Put a check (√) mark in appropriate box.

Companion's full name: _____ Date: _____

Date of Birth: _____ Patient's name: _____ Contact number: _____

Q1. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS WITHIN THE PAST 14 DAYS? ☐ **YES** ☐ **NO**

Respiratory symptoms
- ☐ Cough
- ☐ Colds
- ☐ Throat pain
- ☐ Shortness of breath

Influenza-like symptoms
- ☐ Headache
- ☐ Body pains or muscle pains
- ☐ Diarrhea with or without Vomiting
- ☐ Weakness
- ☐ Lack of smell or taste

Status of respiratory symptoms:
- ☐ Worsening
- ☐ Stable/Improving

☐ **Fever** 38 degrees Celsius or higher

If with symptoms, MAY NOT PROCEED TO THE SUCCEEDING QUESTIONS. Please give your screening form to the healthcare worker. If NO, proceed to Q2.

Q2. DO YOU HAVE ANY UNPROTECTED CLOSE CONTACT WITH A COVID-19 CASE? ☐ **YES** ☐ **NO** proceed to Q3

Were you tested for COVID-19?

☐ YES, proceed to Q4

☐ NO, Have you completed 14 days quarantine? ☐ YES ☐ NO, may not proceed with next questions

****Unprotected close contact – being within approximately six (6) feet or two (2) meters of a person with COVID-19 for approximately five (5) minutes or longer and not wearing a face mask.*

Q3. HAVE YOU BEEN HOSPITALIZED FOR COVID-19 OR PNEUMONIA FOR THE PAST MONTH?

☐ **YES** ☐ **NO** proceed to Q4

If YES: Have you completed 14 days quarantine? ☐ YES ☐ NO

Do you have subsequent NEGATIVE RT-PCR result? ☐ YES NO ☐

Q4. HAVE YOU BEEN TESTED FOR COVID-19? ☐ **YES** ☐ **NO**

Q4.1 Have you had RT-PCR (Swab Test)?

☐ No, proceed to Q4.2

☐ Yes, date of swab test: _____

swab test result: ☐ Positive ☐ Negative

If <u>POSITIVE RT-PCR</u>:

Have you completed 14 days quarantine? ☐ YES ☐ NO

Do you have subsequent RT-PCR Negative result? ☐ YES ☐ NO

Q4.2 Have you had Rapid Antibody Test for COVID-19?

☐ No

☐ Yes, Result: Positive either IgG/IgM ☐
Negative both IgG/IgM ☐

<u>If POSITIVE IgG/IgM:</u> Have you had RT-PCR Test (swab test)? ☐ YES ☐ NO

<u>If RT-PCR not done:</u> Have you completed the 14 days quarantine? ☐ YES ☐ NO

In compliance with RA 11332 *Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act*, I have provided truthful information about my health condition and possible exposure.

Companion's Signature above Printed Name	Relationship to Patient	Date (MMM/DD/YYYY) and Time (00:00)

Companion's Disposition:

- ☐ May accompany patient
- ☐ Refer for Teleconsultation
- ☐ Proceed to Emergency Department
- ☐ Refer to MMC Laboratory for RT-PCR Testing

Validated by:

Healthcare Worker's Signature Above Printed Name	Designation	Date (MMM/DD/YYYY) and Time (00:00)

Validity: This Screening Form is valid for five (5) days. Any symptom which may develop or any unprotected exposure within this coverage period for the Companion will automatically invalidate this initial screening session. Companion should accomplish a new screening form.