ASIAN HOSPITAL AND MEDICAL CENTER
Global Expertise. Filipino Heart.

COVID-19 PATIENT DECLARATION FORM AND TRIAGE ASSESSMENT TOOL

PATIENT'S NAME **Family Name** **Given Name** **Middle Name**			DATE / TIME:
Age:	Sex:	Birthday:	Occupation:
Address:			Contact No.

REPUBLIC ACT NO. 11332. ***Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act.*** It requires the patient to provide truthful information about one's health condition and possible exposure. Violation of this act shall be **PENALIZED with a fine of not less than Php20,000.00 but not more than Php50,000.00 or imprisonment of not less than one (1) month but not more than six (6) months, or both such fine and imprisonment,** at the discretion of the proper court.

PART I. Signs and Symptoms

SYMPTOMS	YES	NO
Cough	☐	☐
Colds	☐	☐
Fever	☐	☐
Difficulty of Breathing	☐	☐
Sore throat	☐	☐
Diarrhea	☐	☐

SYMPTOMS	YES	NO
Loss of appetite	☐	☐
Nausea &/or vomiting	☐	☐
Body weakness / muscle pain	☐	☐
Skin Rash	☐	☐
Eye discharge / pink or red eyes	☐	☐
Decreased sense of smell &/or taste	☐	☐

PART II. Travel AND Exposure History

	YES	NO	DETAILS
Have you or any member of your household traveled out of the country since January 2020?	☐	☐	Country: _____ Date of travel: From _____ to _____
Have you or any member of your household or close contacts traveled to OR reside in an area where there is a reported case or cluster of COVID-19 (+) patients?	☐	☐	
Have you or any of your close contacts or household members been tested for COVID-19?	☐	☐	Result: _____ Date of Testing:_____
Were you exposed to a suspect/probable/confirmed case of COVID-19?	☐	☐	Date of exposure:_____
Did you have a Chest X-ray for the past 6 months?	☐	☐	Result: _____
Have you been to other places (hospital/lying-in/health center) before coming here?	☐	☐	Where: _____ Reason of transfer: _____

PART III. MEDICATIONS. Please enumerate current medicines you are taking.

_____

In accordance with RA11332, we certify that the above declaration is TRUE and CORRECT. We understand that any dishonest answer(s) may have serious public health implications and may be subjected to penalties.

_____/_____

_____

PATIENT'S Printed Name & Signature / Date & Time

COMPANION's Printed Name & Signature and Relationship