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**Guidance for visitors during the COVID-19-pandemic**

**General information about the visitor (please fill in in block letters and legibly!)**

|  |  |
| --- | --- |
| Last Name, First Name: |  |
| Address: |  |
| Mobile Number: |  |
| E-mail-address: |  |
| Visited Patient: |  |
| Hospital Ward and Room Number: |  |
| Date, Time and Duration of the Visit: |  |

**Screening checklist for visitors**

Did one of these symptoms appeared in past 14 days?

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Fever (>38° Celsius)? |  |  |
| Possibly check your temperature |  |  |
| Cough? |  |  |
| Shortness of breath? |  |  |
| Loss of taste and/or smell? |  |  |
| Severe runny nose, if it is not explainable by a previous illness (for example allergic responses like hay fever)? |  |  |
| General fatigue and/or loss of performance, if it is not explainable by a previous illness? |  |  |
| Are you currently in quarantine? |  |  |
| Have you been abroad within the last 14 days or have you been in a particularly affected area in Germany? |  |  |

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Have you been in contact with anyone known to be positive for COVID-19? |  |  |

**Filled in by hospital:**

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Admission of the Visitor was granted? |  |  |

Date, Signature of the Visitor Date, Signature of the Hospital Staff