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COVID-19 Risk Assessment **Date:** _____

1. Do you, a family member or the patient have a cough?
   - Yes
   - No
2. Do you, a family member or the patient have shortness of breath?
   - Yes
   - No
3. Do you, a family member or the patient have a high fever?
   - Yes
   - No
4. If you answered yes to question 3, please note the duration of the fever.
   _____
5. Do you, a family member or the patient have a sore throat?
   - Yes
   - No

Travel and/or contact exposure

6. In the last 14 days, has any family member travelled outside South African borders to areas of local transmission?
   - Yes
   - No
7. In the last 14 days, did you or the patient have close contact with another person who has been tested positive for COVID-19?
   - Yes
   - No

Signature: _____