PATIENT DATA SHEET

Date: _____ Time: _____ AM/PM Thermal Scan temperature: _____ °C

PERSONAL DETAILS

LAST NAME **FIRST NAME** **MIDDLE NAME**

BIRTHDATE (MM-DD-YYYY)

AGE **SEX AT BIRTH** ☐ Male ☐ Female

CONTACT NO/S

RESIDENCE ADDRESS

PHYSICIAN'S NAME *(or indicate N/A if none)*

TEST REQUEST/S *(if applicable)*

HEALTH DECLARATION

In the past 14 days, did you have any of the following:	**NO**	**YES**	
1. Symptoms:			
A. Fever (≥ 37.5°C)			Date of first day of symptoms:
B. Cough			
C. Colds			
D. Shortness of breath			Date of last day of symptoms:
E. Sore throat			
F. Influenza-like symptoms (headache, muscle and joint pain, diarrhea, lack of sense of smell or taste)			
2. History of intake of antibiotics or medications for cough, colds, fever *(past 3 days only)*			
3. Travel to a country outside the Philippines			
4. Household member diagnosed with COVID-19			Date of last exposure:
5. Contact or exposure to a **probable** or **confirmed case**			

Definition of contact or exposure (any of the following):
- Face-to-face contact within 1 meter and for more than 15 minutes
- Direct physical contact
- Direct care for a patient without using proper PPE
- Other situations as indicated by local risk assessments as dictated by the Local Government Unit (LGU)

6. History of COVID-19 infection			Date swabbed: _____
7. History of total antibody **(+) OR** IgM **(+)** and IgG **(-)** rapid antibody result			Date tested: _____
8. History of confinement in the hospital			Reason: _____ Date of discharge: _____

Please note that in compliance with RA 11332 or the Mandatory Reporting of Notifiable Diseases and Health Events of Public Health Concern Act, those who will be classified as possible, suspect and probable COVID cases will be reported to Regional Epidemiology and Surveillance Units (RESU). **The same act also requires that the information that you provide regarding your health condition and possible exposure are true.**

☐ As a **private client**, I understand that I must personally claim or access my results online. If I am unable to personally claim my results, I authorize the release of my results via the following delivery modes:

☐ by proxy pick-up, s/he must present an authorization letter with an attached copy of my and his/her valid I.D.

☐ by sending the physical copy to _____.

☐ As a **corporate client**, I understand that I must abide by the instructions given to me by my employer / company / HMO / insurance agent / broker regarding release of results. When required, I also give my consent and allow HPD to post online and/or forward all the results of my medical examination including, but not limited to laboratory and ancillary examinations, to my employer / company / HMO / insurance agent / broker _____.

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By signing this registration form, you confirm that you accept our processing of your information and agree to our Privacy Policy.

_____ _____

Patient or Legal Guardian's* Signature over Printed Name / Date Signed Triage Staff

**Note: If signing as legal guardian for minor or incapacitated patient, please indicate the relationship to patient:* _____