Visual Triage Checklist

To be retained by Screening team

Visual Triage Checklist for Acute Respiratory Illness

Name: _____ Age/Gender_____/_____

Date: _____ Time: _____ Contact No.: _____

Current Address: _____

Scenario	Risk of exposure to COVID 19	Action
I	A history of travel to COVID affected areas in the last 14 days (as per enclosed list to be updated on daily basis) without symptoms Or Asymptomatic with Contact with a COVID Positive case in the last 14 days	**Home quarantine**
II	A history of travel to COVID affected areas (as per enclosed list to be updated on daily basis) in the last 14 days prior to onset of symptoms or Contact with a COVID Positive case in the last 14 days of onset of symptoms +	**Hospital Isolation**
	Any following Clinical Symptoms/Sign	
	Fever>/= 37.8	
	Cough (New or Worsening)	
	Shortness of breath (New or Worsening)	
	Sore throat and/or runny nose	
III	No travel history in the last 14 days with none of the above clinical symptoms	**Screening clearance to be issued**
IV	Any of the above symptoms with history of domestic travel within last 14 days of onset of symptoms	**Clearance to be given with Advise to use PPE and limit exposure to others and report if symptoms worsens**

Screening Staff Name:

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