**Essential /Designated Visitor Trace and Protect Record**

Patient Address Label

**Ward: .............................................................**

**Hospital: ........................................................**

**Welcome**

It is very important for the health and wellbeing of patients and staff that you **do not visit** if you have been feeling unwell in any way or have symptoms of Covid-19.

As a visitor for someone in hospital, we ask you to provide your contact details to ensure the safety and wellbeing of patients, visitors and staff. This is normal in the current circumstances to assist Public Health, Trace and Protect colleagues should there be a need to contact you.

Please read the information below, answer each question, and complete your contact details at the bottom to help us assess that you are safe to visit.

|  |  |  |
| --- | --- | --- |
| **TRACE & PROTECT QUESTIONNAIRE** | **YES** | **NO** |
| Are you feeling unwell? |  |  |
| Do you have a new/continuous cough? |  |  |
| Have you had any sickness or diarrhoea within the last 48 hours? |  |  |
| Have you noticed a change in your temperature? |  |  |
| Have you noticed a change in your normal sense of taste or smell? |  |  |
| Are you self isolating because you have been in contact with anyone suspected as having, or has tested positive for coronovirus, in the past 14 days? |  |  |
| You agree to supply your contact details. If required these will be used by Public Health as part of the “Test and Protect” strategy, should there be a necessity to contact you following your visit to the hospital. This information will be securely destroyed once the information is no longer required. |  |  |

|  |  |
| --- | --- |
| **Name:** |  |
|  |  |
| **Address & Postcode:** |  |
|  |  |
| **Home telephone number/ mobile:** |  |
|  |  |
| **Date of visit:** |  |
| **Room No & Bed No. of Patient** |  |
| **Time of arrival:** |  |
| **Time of departure:** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time of Arrival** | **Time of Leaving** | **Any change to symptom checklist**  **YES / NO** | **Patient Position in Ward** | | |
| **Ward No.** | **Room No.** | **Bed No.** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |