

**Triage-Fragebogen**  
**grippaler Infekt/Influenza/Corona**  
- Klinikum WHV -

Name of Patient: \_\_\_\_\_

Ward: \_\_\_\_\_

Name, First Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Hospital Admission: Reason: \_\_\_\_\_

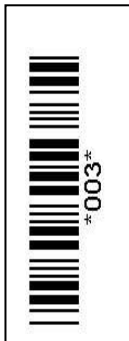
Date: \_\_\_\_\_

Time: \_\_\_\_\_

Symptoms	Yes	No	Severity			Start of Symptoms
			slight	moderate	severe	
Sudden onset of illness?	<input type="checkbox"/>	<input type="checkbox"/>				
Acute distress						
At rest?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
At stress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>				max °C
Exhaustion / tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
cough*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Common cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Taste disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Smelling disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Others (e.g. swallowing pain, rash)						

\*if cough exists use regular breathing mask.

did you visit a foreign country in the last 14 days	<input type="checkbox"/> no <input type="checkbox"/> yes, destination?
Have you recently had contact with a person with Corona-infection?	<input type="checkbox"/> no <input type="checkbox"/> yes, location of contact?
Have you recently had contact with a person <b>suspected for a</b> Corona-infection	<input type="checkbox"/> no <input type="checkbox"/> yes, location of contact?
do you have a weak immune-system due to any known illness?	<input type="checkbox"/> no <input type="checkbox"/> yes, which illness?
Are you suffering from any chronic diseases?	<input type="checkbox"/> no <input type="checkbox"/> yes, which disease?
Are you currently employed in any medically relevant field?	<input type="checkbox"/> no <input type="checkbox"/> yes, where?
Have Corona throat smears already been carried out with you?	<input type="checkbox"/> no <input type="checkbox"/> yes, Date: _____ Result: <input type="checkbox"/> negative <input type="checkbox"/> positive



\_\_\_\_\_  
Date / Sign Visitor, Patient or Interviewer (has to be filled on day of visit)