FORM – I A

IMA FEVER / RESPIRATORY CLINIC

Vadavalli, Coimbatore

PATIENT NAME: AGE/SEX: y/

PHONE NUMBER:

ADDRESS:

SYMPTOMS:

	YES	NO	DURATION
COUGH			
FEVER			
DIFFICULTY IN BREATHING			
COLD			
FATIGABILITY			
DIARRHEA			
LOSS OF SMELL			

DATE OF SYMPTOM ONSET:

VITALS: TEMP: , PR: , SPO2: %, BP: mm/hg RR:

COMORBIDITIES:

☐ DM ☐ SHT ☐ BA ☐ COPD ☐ CAD ☐ HEART FAILURE

☐ CKD ☐ ESRD ON HEMO DIALYSIS ☐ TRANSPLANT ☐ CANCER

☐ CLD ☐ CVA ☐ MUSCULAR DYSTROPHIES

- H/O TRAVEL TO ANY COUNTRY IN THE LIST IN THE LAST 15 DAYS
  UK / US / CHINA / JAPAN / THAILAND / INDONESIA / IRAN /
  DUBAI / KATAR / SPAIN / ITALY.
  KERALA / BENGALURU / DELHI / MUMBAI, CHENNAI, ERODE
- H/O TRAVEL – to positive countries/states/ districts/ areas
- H/O CONTACT WITH PEOPLE WHO TRAVELED TO THE ABOVE PLACES IN THE LAST 15 DAYS
- H/O ANY MASS GATHERING ATTENDED IN THE LAST 15 DAYS
- H/O CONTACT WITH PEOPLE ON QUARANTINE
- H/O CONTACT WITH COVID POSITIVE PATIENTS

CAT – A	CAT – B	CAT – C
RESPIRATORY SYMPTOMS ONLY	RESPIRATORY SYMPTOMS WITH CO MORBIDITIES	RESPIRATORY SYMPTOMS WITH RESPIRATORY DISTRESS
NO CO MORBIDITIES	WITHOUT ANY RESPIRATORY DISTRESS	WITH OR WITH OUT CO MORBIDITIES
NO SIGNS OF RESPIRATORY DISTRESS	PR < 100/MIN, SPO2 >94%, BP> 90/60, RR <24.	PR > 100/MIN, SPO2 <94%, BP< 90/60, RR >24.

NOTIFICATION TO JDHS / DDHS:

- IF ANY HISTORY OF TRAVEL TO THE IDENTIFIED COUNTRIES IN THE LAST 15 DAYS
- H/O CONTACT WITH PEOPLE WHO HAVE TRAVELLED TO THE ABOVE COUNTRIES
- H/O CONTACT WITH PEOPLE WHO ARE CONFIRMED TO BE COVID POSITIVE
- H/O NEW ONSET RESPIRATORY DISTRESS WITHIN 15 DAYS PERIOD

SIGNATURE OF THE DOCTOR

REGI NO:

DF&RC CLINIC ADDRESS:

Health & Family Welfare Department, Government of Tamil Nadu

FORM 1

SCREENING AND TRIAGE FOR COVID-19

1.	H/o Fever	☐ YES	☐ NO
2.	Any one of the following: a) H/o Cough b) H/o difficulty in breathing c) Or any **signs** of respiratory disease	☐ YES	☐ NO
3.	Any one of the following: a) H/o Travel to or residence in a country/ area or territory reporting local transmission in the last 14 days prior to onset of symptoms b) H/o contact with COVID-19 confirmed case in the last 14 days prior to onset of symptoms c) Severe Acute Respiratory Infection (SARI) **AND** requiring hospitalization **AND** with no other etiology that fully explains the clinical presentation (including health care provider)	☐ YES	☐ NO

If answers to **all (1,2 and 3) questions are YES**, consider the patient as **SUSPECT for COVID-19**

- **Report** to 24x7 control room with case details.
- **Refer** to designated hospital through dedicated ambulance arranged by Government authority.

If **1 or 2 or both is YES**, consider the patient as **Acute Respiratory Infection and follow the existing protocol.**

If **only 3 is YES** immediately contact to 24x7 Control room.

- REFERRAL
- TREATED

SIGNATURE OF THE DOCTOR

REGI NO:

DF&RC CLINIC ADDRESS:

FORM - II

NOTIFICATION FORM

PATIENT NAME: AGE/SEX: y/

PHONE NUMBER:

ADDRESS:

SYMPTOMS:

	YES	NO	DURATION
COUGH			
FEVER			
DIFFICULTY IN BREATHING			
COLD			
FATIGABILITY			
DIARRHEA			
LOSS OF SMELL			

TRAVEL HISTORY : YES / NO

CATEGORY : A B C

CONTACT NUMBERS: 1. JDHS

2. DDHS

INFORMED TO WHOM:

SIGNATURE OF THE DOCTOR

REGI NO:

DF&RC CLINIC ADDRESS: