

Questionnaire Covid-19 Rapid Test

Patientenetikette

To be filled out by the patient:

1. In which language would you like to receive the test results?

- deutsch
- english

2. Reason for testing

(including date and destination if for travelling reasons): _____

3. Do you suffer from any the following diseases?

- High blood pressure
- Chronic respiratory disease
- Diabetes
- Disease or therapy which weakens the immune system
- Cardiovascular disease
- Cancer
- High level of obesity (BMI over 40 kg/m²)
- No, I have none of the above-mentioned diseases.**

4. Do you have one or more of the following symptoms?

- Coughing
- Sore throat
- Breathlessness
- Loss of smell and/or taste
- Fever, feverish feeling or muscle pain
- No, I do not have any of the above-mentioned symptoms.**

5. Have you been in close contact with a person, who has been tested positive to Covid-19 within the last 10 days?

- Yes
- No

6. Passportnumber of patient

(if it is desired to be noted on the test result): _____

7. Date: _____ Signature of patient: _____

To be filled out by the health care personnel:

Grund für Testung:

- KVG
- UVG
- Selbstzahler