Pre-Boarding Medical Screening Form for COVID-19

MEDICAL CONFIDENTIAL

TODAY'S DATE:	**TIME:**
SHIP NAME:	**LOCATION:**
PATIENT LAST NAME:	**FIRST NAME:**
GENDER: ☐ **M** ☐ **F**	**DATE OF BIRTH** (*dd/mm/yyyy*)
NATIONALITY:	**COUNTRY OF RESIDENCE:**
CABIN NUMBER:	**DEPARTMENT/RANK & ID** (*for crew*)**:**
CONTACT PHONE #:	**EMAIL ADDRESS:**

CHIEF COMPLAINT:					
DOES THE INDIVIDUAL HAVE ANY COMPLAINTS OR SYMPTOMS LISTED BELOW? (Check all that apply) ☐ Fever ☐ Feverishness/Chills ☐ Cough ☐ Shortness of breath/difficulty breathing ☐ Sore Throat ☐ Fatigue ☐ Muscle Aches ☐ Headaches ☐ Congestion/runny nose ☐ New loss of taste/smell ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ OTHER (list)_________________________________ ☐ NONE					
If YES: Date of First Symptom Onset: _______________________					
PHYSICAL APPEARANCE:					
VITAL SIGNS	**TEMP (°C/°F)**:	**BP:**	**PULSE**:	**SpO2**:	**RR**: /min

IN THE PAST 14 DAYS:

1. Have you had close contact with a laboratory-confirmed COVID-19 case?	☐ Y ☐ N ☐ Unknown
2. Have you had provided care for someone with COVID-19, or worked with a health care worked infected with COVID-19?	☐ Y ☐ N ☐ Unknown
3. Have you visited or stayed in close proximity to anyone with COVID-19?	☐ Y ☐ N ☐ Unknown
4. Have you worked in close proximity to, or shared the same classroom environment with, someone with COVID-19?	☐ Y ☐ N ☐ Unknown
5. Have you travelled with a patient with COVID-19 in any conveyance?	☐ Y ☐ N ☐ Unknown
6. Have you lived in the same household with a patient with COVID-19?	☐ Y ☐ N ☐ Unknown
7. If Yes to any of questions 1-6, please provide more details about the index case, including the location, date, duration and type of exposure.	

All Pre-embarkation Forms to comply with HIPAA & GDPR requirements. The documents will be processed and stored in the medical center. The documents will be kept for a minimum of 1 year.

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For patients that undergo further clinical assessment:

Does the patient have another diagnosis (other than possible COVID-19) or etiology that may explain their respiratory symptoms?	☐ Y ☐ N ☐ Not clinically assessed
If yes, please provide details:	

For patients with respiratory diagnostic test results (prior to arrival or conducted at pier before boarding):

SPECIMEN TYPE	POSITIVE	NEGATIVE	PENDING	NOT DONE	DATE	SENT TO HEALTH AUTH?
COVID-19 PCR	☐	☐	☐	☐		
COVID-19 Antigen Rapid	☐	☐	☐	☐		
Other, specify_________	☐	☐	☐	☐		

Risk Assessment:

Are the individual and close contacts cleared for boarding? If yes, any restrictions?	☐ **Y** ☐ **N**
If no, is this person referred to a shoreside medical facility for further evaluation?	☐ **Y** ☐ **N** ☐ **Unknown**
If Yes, where is this person being referred to?	
If review by ship's Nurse, was this person referred to ship's Doctor? **Doctor signature ____**	☐ **Y** ☐ **N**
Consulted with Vikand's Chief Medical Officer and/or Captain? **If Yes, provide date and time_________________________________**	☐ **Y** ☐ **N**

Medical Staff Name: **Rank:**

Date of Assessment: **Signature:**

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