Pre-Boarding Secondary Medical Screening Evaluation Form

MEDICAL CONFIDENTIAL

All passengers, crew, contractors and day visitors must complete this declaration before boarding the vessel. Failure to complete this document could result in delayed or denial of boarding.

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

CURRENTLY AND 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 worker infected with COVID-19?	☐ Y ☐ N ☐ Unknown
3. Have you visited or stayed in close proximity to anyone with COVID-19 or any other acute respiratory illness, such as viral Influenza or Pneumonia?	☐ 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

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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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.

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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