

Hemodialysis Patient Screening Questionnaire for Influenza-like Illness/COVID-19 (Simplified Chinese)

► Please complete for every patient at every HD visit prior to the patient's entry into the HD unit.

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

Date of Birth (MM/DD/YYYY): _____

PHN: _____

Date: _____

On arrival, ask the patient each of the following 5 questions:

患者是否有以下情况: Does the patient:	是 Yes	否 No	工作人员简签 Staff Initial
1. 体温是否超过37.5度或自我检验呈发烧症状? Have a temperature ≥ 37.5 or self-reported fever?			
2. 是否有喉咙痛? Have a sore throat?			
3. 是否有新的或恶化的咳嗽症状(与正常基准相比)? Have a new or worsening cough (compared to their baseline)?			
4. 是否有呼吸困难/呼吸急促的症状(与正常基准相比)? Have difficulty breathing/shortness of breath (compared to their baseline)?			
5. 是否在过去的14天内与确诊或疑似患有新型冠状病毒(COVID-19)的人有过密切接触? Report close contact with a known or suspected COVID-19 positive person within the past 14 days?			

在筛查过程中,患者是否提到以下其他症状(请勾选所有适用症状)

During the screening process, did the patient mention any other symptoms (check all that apply):

肌肉痛 Myalgia <input type="checkbox"/>	腹痛 Abdominal pain <input type="checkbox"/>
不适 Malaise <input type="checkbox"/>	腹泻 Diarrhea <input type="checkbox"/>
头痛 Headache <input type="checkbox"/>	恶心/呕吐 Nausea/vomiting <input type="checkbox"/>
打喷嚏 Sneezing <input type="checkbox"/>	味觉或嗅觉丧失 Loss of taste or smell <input type="checkbox"/>
流鼻涕/鼻塞 Runny nose/nasal congestion <input type="checkbox"/>	丧失食欲 Loss of appetite <input type="checkbox"/>
发冷 Chills <input type="checkbox"/>	其他新的症状(请具体说明) _____ Other new symptom (Please specify)

► If the answer to at least 1 question above is "yes", please place the form in the designated box.