RISK ASSESSMENT QUESTIONNAIRE

Gynera FERTILITY CENTER

For the protection of patients and staff during the COVID-19 pandemic, the Gynera Clinic has implemented additional precautions related to the transmission of the new virus.
Please answer the questions below honestly and confirm your understanding and compliance with recommendations. They will help us to take appropriate measures to reduce risks and protect you, the team and other patients.

Name and surname:
Date of birth:

Contact details
(phone / email):

	Yes	No	Comments
Have you been sick in the last two weeks?	☐	☐	
Do you have fever (over 37,5°C)?	☐	☐	
Are you coughing at present?	☐	☐	
Do you have a sore throat?	☐	☐	
Have you lost your sense of smell or taste?	☐	☐	
Have you been in contact with somebody who has any of these symptoms?	☐	☐	
Have you travelled to an area at high risk for COVID-19, nationally or internationally?	☐	☐	
Do you work in a hospital/nursing home or healthcare facility?	☐	☐	
Have you been in contact with somebody who has COVID-19?	☐	☐	
Have you been diagnosed with COVID-19?	☐	☐	
Do you live in a household with somebody who has been diagnosed with COVID-19 infection or has COVID-19 symptoms (fever, cough, loss of smell)?	☐	☐	
If you have been COVID-19 positive and recovered, do you have certified medical evidence of clearance ?	☐	☐	
Do you have a severe medical condition like diabetes, respiratory disease, chronic kidney disease, etc.?	☐	☐	

Questionnaire according to the ANT / ESHRE 2020 recommendations

Knowing the provisions of Art. 326 of the Criminal Code regarding false statements, I declare on my own responsibility that all information provided by completing this questionnaire are complete, correct and valid at the time of signing.

I will contact the clinic by phone or email, in case I have symptoms or direct contact with a confirmed person Covid-19 and I will not come directly to the clinic under these conditions.

I confirm that I will follow the recommended protection measures (distance from other people, wearing a mask and other recommendations which I will receive from the clinic staff, including the measure of self-isolation / isolation, if necessary).

At the time of completing this questionnaire I am not subject to any restrictive measures imposed by the national authorities on the Romanian territory and / or of other states such as: quarantine type restrictions, self-isolation, leaving the domicile / state.

Date & signature:

Responsible for evaluation:

All information provided is confidential and will only be used in connection with the mentioned epidemic risk.

DEC-AD-Cov Iunie 2020 Ed3 Eng