

MUST ATTACH PATIENT LABEL HERE

SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NHI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST NAMES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Please ensure you attach the correct patient label

 **COVID 19 Screening**

 **Maternity**

|  |
| --- |
| **Screening questions for maternity women except elective Caesarean section** |

**If answered YES to any one of the questions below:**

Escalate to CM/CN/CMM/shift coordinator who will follow ‘Screening and care guide of women entering Assessment unit (WAU) or Labour and Birthing suite (LBS)’ flow diagram

**If answered NO to all the questions below:**

Give advice to attend as per clinical situation.

|  |  |
| --- | --- |
| 1. Have you or anyone in your household returned from overseas in the last 14 days?
 |  [ ]  Yes [ ]  No |
| 1. Do you have any of the following symptoms:
* Cough
* Sore throat
* Shortness of breath
* runny nose, sneezing, post-nasal drip
* Loss of sense of smell
* Temperature
 | [ ]  Yes [ ]  No |
| 1. Are you a Health Care Worker?
 | ☐ Yes ☐ No |
| 1. In the last 14 days, have you had close or casual contact with, or are you living with, someone with confirmed, probable or suspected COVID 19, or who has been told by Health line to self-isolate?
 | [ ]  Yes [ ]  No |
| 1. 4. Are you waiting for or have received a COVID-19 swab result?
 | ☐ Yes ☐ No |
| ***Birth support person screening*** |
| 1. Has your birth support person been unwell in the past 48 hours or been asked to self-isolate?
 | [ ]  Yes [ ]  No |

Name of Screener: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time:\_\_\_\_\_\_\_\_

NB: Document screening answers on the HW Risk sheet under ‘other maternal medical’

Add all screen positive inpatients to high risk board for handover and CHIPs whiteboard