$IIL[62+ ,62+ LGHQWLILFDWLRQ ODEHO KHUH

0HWUR 6RXWK +RVSLWDO DQG +HDOWK 6HUYLFH

0HWUR 6RXWK +HDOWK

5HIXJHH $V\OXP 6HHNHU 5HIHUUDO)RUP

&OLHQW 'HWDLOV	&OLHQW (OLJLELOLW\ 'HWDLOV
7LWOH 6H[0) I	'RHV WKH FOLHQW JR WR VFKRRO" 1R <HV
)DPLO\ QDPH	,V WKH FOLHQW D 0HGLFDUH HOLJLEOH 5HVLGHQW 1R
*LYHQ QDPH V	$UULYDO LQ 4XHHQVODQG GG PP \\\\
'DWH RI ELUWK GG PP \\\\	$V\OXP VHHNHU 5HIXJHH
$GGUHVV	9LVD 7\SH
6XEXUE	0HGLFDUH &DUG GHWDLOV
7HOHSKRQH	0HGLFDUH &DUG 1R
&RXQWU\ RI %LUWK	5HIHUHQFH 1R ([SLU\ GDWH PP \\
,QWHUSUHWHU UHTXLUHG 1R <HV	+HDOWK &DUH &DUG RU 3HQVLRQ &DUG GHWDLOV
/DQJXDJH VSRNHQ	&RQFHVVLRQ &DUG 1R
2WKHU FXOWXUDO UHTXLUHPHQWV	([SLU\ GDWH GG PP \\
,QWHUSUHWHU SUHIHUHQFH)HPDOH 0DOH 1R 3UHIHUHQFH	

3UHIHUUHG 'HQWDO &OLQLF

KWWS PHWURVRXWK KHDOWK TOG JRY DX RUDO KHDOWK FOLQLFV

3UHIHUUHG &OLQLF

5HDVRQ IRU XUJHQW FDUH GHQWDO H[DPLQDWLRQ HWF 3OHDVH

5HIHUUDO)URP

1DPH	3RVLWLRQ
$JHQF\	&RQWDFW 1XPEHU
6LJQDWXUH	&RQWDFW (PDLO
'DWH	

'HPRJUDSKLFV HQWHUHG LQ ,62+	'DWH RI DSSRLQWPHQW	6WDII PHPEHU QDPH
3ODFHG RQ 5HIHUUDO ZDLWOLVW		
'HQWDO DVVHVVPHQW DQG DSSRLQWPHQW		
,QWHUSUHWHU ERRNHG		
5HIHUUDO VFDQQHG LQWR (&5		

'2 127 :5,7(,1 7+,6 %,1',1* 0$5*,1

)0

2UDO +HDOWK 6WDII 8VH 2QO\ Y

0(752 6287+ 25$/ +($/7+ 5()(55$/)250

COVID screening questions for Refugees and Asylum seekers requesting Emergency Oral health care from MSOH

1. Have you experienced any of the following in the last 7 days? ☐ Yes ☐ No
   - Cough
   - Fever
   - Shortness of Breath
   - Sore throat
   - Runny Nose
   - Fatigue
   - Loss of sense of smell or taste

2. Have you travelled interstate or overseas in the last 14 days? ☐ Yes ☐ No

3. Have you been in contact with a person suspected or confirmed of having COVID-19? ☐ Yes ☐ No
   If yes, date of most recent contact _____

4. Have you been instructed to self- isolate or self-quarantine? ☐ Yes ☐ No

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Refugees and Asylum seekers requiring Urgent Dental treatment from MSOH

Please indicate the symptoms the patient is presenting with indicating urgent care

Trauma / Injury	☐ Yes	☐ No
Swelling in the face	☐ Yes	☐ No
Swelling in the mouth	☐ Yes	☐ No
Uncontrolled bleeding	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Pain when eating	☐ Yes	☐ No
Broken Tooth	☐ Yes	☐ No
Broken Denture	☐ Yes	☐ No

Other _____