



MELBOURNE LUNG & SLEEP SPECIALISTS

All Patients undertaking lung function testing at Melbourne Lung and Sleep Specialists
MUST complete the details below to protect our patients and staff during the pandemic.
Thank you.

First and Last Name: _____

Are you experiencing any of the following symptoms? Over and above your usual issue/s;

- | | |
|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of smell or taste |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Breathing difficulties or wheezing | <input type="checkbox"/> Headache |
| | <input type="checkbox"/> NO |

Have you had a positive COVID test in the last 7 days?

- Yes No

Have you been tested for COVID and are awaiting results?

- Yes No

Have you been in close contact with a confirmed COVID positive person in the last 7 days? (e.g. household contact)

- Yes No

I believe the above to be true and correct at the time of completion.

Signed: _____

Date: _____