A.O. S.Croce e Carle Cuneo	**MOD$_{COVID_19}$** **TRIAGE CORONAVIRUS** paziente; accompagnatore; visitatore; tecnico; specialist (autorizzato dal personale della struttura)	Data prima emissione: marzo 2020 Data ultima revisione: 13 agosto 2020

INFORMATION FOR THE PROCESSING OF PERSONAL DATA (personal data will be processed as indicated below):

Information for the processing of personal data under EU regulation 2016/679 to supplement the general information available on the website: www.ospedale.cuneo.it, section: "Protection of personal data," Santa Croce e Carle Hospital, as Data Controller, informs that the personal data collected through this form will be processed to apply the prevention measures defined by the "Guidelines for the resumption of health activities" of the Piedmont Region of 14/05/2020 and "Implementation provisions for the prevention and management of the epidemiological emergency from COVID-19" of the Ministry of Health of 27/05/2020. The processing is necessary for the public interest in the public health sector, according to the Article 9, paragraph 2, letter *i*.

PARTE DA COMPILARE A CURA DELL'UTENTE

PART TO BE FILLED IN BY THE USER

Il sottoscritto, consapevole delle responsabilità penali e degli effetti amministrativi derivanti dalla falsità in atti e dalle dichiarazioni mendaci

The undersigned, aware of the criminal responsibilities and administrative effects deriving from falsification of documents and false declarations

AUTOCERTIFICA QUANTO SEGUE:

SELF-CERTIFIES THE FOLLOWING:

Date ……/……/…… Time ……

The undersigned ……*COGNOME E NOME*…… born on …… in ……

ATTUALMENTE È IN ISOLAMENTO FIDUCIARIO IS CURRENTLY IN FIDUCIARY ISOLATION	SI ☐YES	NO ☐NO
PROVIENE DA UNA STRUTTURA RESIDENZIALE (Casa di Riposo; Lungodegenza; Struttura Riabilitativa) → se sì consegnare scheda della struttura COMES FROM A RESIDENTIAL STRUCTURE (Nursing Home; Long-term Ward; Rehabilitation Facility) → if yes, please give the structure's document	SI ☐YES	NO ☐NO
E CHE NEGLI ULTIMI 14 GIORNI HA AVUTO: **AND THAT IN THE LAST 14 DAYS HE/SHE HAD:**		
UN CONTATTO STRETTO (vedi retro) CON CASO CONFERMATO COVID - 19 A CLOSE CONTACT (see back) WITH A CONFIRMED COVID-19 CASE	SI ☐YES	NO ☐NO
UN DECESSO DI FAMILIARE CONVIVENTE PER CAUSE INSPIEGATE A DEATH OF A FAMILY MEMBER FOR UNEXPLAINED CAUSES	SI ☐YES	NO ☐NO
UN ACCESSO IN STRUTTURA/REPARTO CON PAZIENTI COVID – 19 ACCERTATI AN ACCESS TO A STRUCTURE/WARD WITH CERTIFIED COVID-19 PATIENTS	SI ☐YES	NO ☐NO
FEBBRE (> 37.4 °C) FEVER (> 37.4 °C)	SI ☐YES	NO ☐NO
TOSSE COUGH	SI ☐YES	NO ☐NO
DIFFICOLTA' A RESPIRARE / MANCANZA DI FIATO (dispnea) DIFFICULTY IN BREATHING / LACK OF BREATH (dyspnea)	SI ☐YES	NO ☐NO

Se positivo almeno un criterio tra quelli sopra autocertificati: CASO SOSPETTO COVID – 19

If positive, at least one of the above self-certified criteria: COVID-19 SUSPECT CASE

RAFFREDDORE (rinite) COLD (rhinitis)	SI ☐YES	NO ☐NO
MAL DI GOLA (faringodinia) SORE THROAT (pharyngodynia)	SI ☐YES	NO ☐NO
DOLORI MUSCOLARI / STANCHEZZA/ AFFATICAMENTO MUSCLE PAIN / TIREDNESS / FATIGUE	☐SI ☐YES	☐NO ☐NO
NAUSEA/VOMITO/DIARREA NAUSEA/ VOMITING/ DIARRHEA	SI ☐YES	NO ☐NO
PERDITA DELLA CAPACITA' DI SENTIRE ODORI E/O SENSAZIONE DEL GUSTO (disosmia / disgeusia) LOSS OF THE ABILITY TO SMELL AND/OR SENSATION OF TASTE (dysosmia/dysgeusia)	SI ☐YES	NO ☐NO
CONGIUNTIVITE CONJUNCTIVITIS	SI ☐YES	NO ☐NO

Se positivi almeno due criteri tra quelli sopra autocertificati: CASO SOSPETTO COVID - 19

If positive at least two of the above self-certified criteria: COVID-19 SUSPECT CASE

(Firma del dichiarante) Signature of the declarant _____

PARTE DA COMPILARE A CURA DEL PERSONALE SANITARIO

PART TO BE FILLED IN BY THE HEALTHCARE STAFF

Se l'utente proviene da una struttura residenziale:

If the patient comes from a residential structure:

DISPONIBILE "*MOD$_{INTERAZIENDALE}$010_Triage coronavirus_modulo di invio da una struttura residenziale*" AVAILABLE "*MOD$_{INTERAZIENDALE}$010_Triage coronavirus_ submission form from a residential facility* "	SI ☐YES	NO ☐NO
PAZIENTE IDONEO ALL'ACCESSO PATIENT SUITABLE FOR ACCESS	SI ☐YES	NO ☐NO

NOTE:
ANNOTATION:

SE IL PAZIENTE VIENE INVIATO A DOMICILIO INDICARE:

IF THE PATIENT IS SENT AT HOME, INDICATE:

N° tel. (Tel. no.)_____ Indirizzo (Address)_____

Città (City)_____

Cognome sul citofono (Surname) _____

TUTTE LE SCHEDE POSITIVE DEVONO ESSERE INVIATE VIA FAX (1035) ALLA DSP.

ALL DOCUMENTS WITH POSITIVE DATA MUST BE SENT VIA FAX (1035) TO THE DIRECTION.

(Matricola Operatore sanitario del pre triage che ritira la scheda)

Registration number pre-triage healthcare personnel who collects the paper _____

CRITERIA TO DEFINE A CLOSE CONTACT:

- Coexistence with a case of COVID-19;
- Direct physical contact with a COVID-19 case (e.g., handshake);
- Direct unprotected contact with secretions from a COVID-19 case (e.g., touching used paper handkerchiefs with bare hands);
- Direct contact (face to face) with a case of COVID-19, at a distance of fewer than 2 meters and more than 15 minutes;
- Stay in a closed environment (for example, classroom, meeting room, hospital waiting room) with a case of COVID-19 for at least 15 minutes, at a distance of fewer than 2 meters;
- Direct assistance to a case of COVID-19 or activities in the laboratory with the manipulation of samples of a COVID-19 case without the use of recommended measures of protection or through the use of unsuitable measures of protection;
- A passenger traveling by airplane in the two adjacent seats, in any direction, of a case of COVID-19 without severe symptoms and who did not move inside the aircraft.
- A passenger traveling by airplane, or person in charge of assistance or a crew member staying in a part of the plane where a case of Covid-19 with severe symptoms had remained seated.
- A passenger traveling by airplane, or person in charge of assistance or a crew member staying in a part of the plane where a case of Covid-19 with severe symptoms had moved.