Kitty Lamprecht

Neurofeedback
Neuro-Science Coaching
Neuro-Physiotherapist

BSC Physiotherapy
BSC (Hon) Physiotherapy
MSc Physiotherapy
BA Indus Psych
BA Hon (Indus Psych)

Practice nr: 7234104
HPCSA nr: PT0036927

Patient: _____ I.D nr: _____

Home address: _____

(Physical address where you can be contacted for the next 30 days)

Referring doctor: (Name and telephone number) _____

Do you have any flu-like symptoms **OR** have you had close contact with anyone displaying flu-like symptoms?

Fever higher than 38	YES	NO
Difficulty in breathing/shortness of breath	YES	NO
Coughing	YES	NO
Sore throat	YES	NO
Loss of smell and/or loss of taste	YES	NO
Body aches	YES	NO
Nausea, vomiting, diarrhea	YES	NO
Fatigue/weakness	YES	NO
Any other flu like symptoms	YES	NO

Are you under investigation for COVID 19? YES NO

Have you been in close contact with a person that is under investigation COVID 19? YES NO

Do you have any reasonable suspicion of COVID 19? YES NO

Have you been admitted for pneumonia in the last 14 days? YES NO

Have you worked in or attended another health care facility where you treated/cared for COVID 19 patients?
YES NO

Have you traveled in the last 14 days? YES NO

If so where did you traveled to? _____

I, _____ (full name) confirm that the information given has been correct and truthful.

_____ _____

Signature Date

Signed at: _____