**Knowsley MBC internal use:**

**From:**

**Requesting:**

**Reason for request:**

**Staff Testing for COVID 19 Referral Form**

**COVID-19:** This form should be completed and sent to covid19swabbing@knowsley.gov.uk no later than 3 days from the onset of symptoms. The form will be reviewed and a decision made as to whether the self-isolating staff member or member of their household requires testing. NB The household refers to individuals the staff member resides and currently self isolates with (and NOT the residents of the home in which they work).

**After 7 days of self-isolation, people who feel better and no longer have a high temperature can return to their normal routine.**

**Cough may persist for several weeks in some people, despite the coronavirus infection having cleared. A persistent cough alone does not mean someone must continue to stay at home for more than 7 days.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Staff member’s name** | **Staff member’s job title** | **Department** | **Organisation** |
| **Staff member’s contact number** | **Staff Members DOB** | **Staff Members Address** | **Staff Members Postcode** |
| **Staff member’s email** | **Date form completed** | **Manager** | **Managers Title** |

**Please complete the following:**

|  |  |
| --- | --- |
| 1. Description of symptoms

**Please include:*** A new continuous cough
* High temperature (of 37.8 degrees centigrade or higher)
* Describe any other symptoms:
 |  |
| 1. Date symptoms started (check if over 5 days)
 |  |
| 1. Date of last working day
 |  |
| 1. Date expected back to work
 |  |
| 1. Are you currently in a ‘business critical role’?
 |  |

**Please indicate the staff member’s current status:**

|  |  |
| --- | --- |
| 1. Staff who are symptomatic who are, self-isolating, live alone or with other household contacts
 |  |
| 1. Household contacts who are symptomatic which is causing the staff member to self-isolate.
 |  |
| 1. Staff member who has developed symptoms during self-isolation and lives with a household contact who has tested positive
 |  |

**STAFF ARE REMINDED THAT IT IS ESSENTIAL THAT ACCURATE INFORMATION IS GIVEN, AS FALSE INFORMATION COULD PUT PATIENTS AND OTHERS AT RISK.**

**BY COMPLETING THIS FORM YOU GIVE YOUR CONSENT TO YOUR PERSONAL INFORMATION BEING SHARED WITH THE RELEVANT AUTHORITIES.**

**Household Members Testing for COVID 19 Referral Form**

|  |  |
| --- | --- |
| **Household Members Name:** |  |
| **Household Members Date of Birth:** |  |
| **Contact No.** |  |
| **Address if home visit required:** |  |

**Please complete the following:**

|  |  |
| --- | --- |
| Description of symptoms**Please include:*** A new continuous cough
* High temperature (of 37.8 degrees centigrade or higher)
* Describe any other symptoms:
 |  |
| Date symptoms started (check if over 5 days) |  |

**Please indicate the Household Members current status:**

|  |  |
| --- | --- |
| 1. Household contacts who are symptomatic which is causing the staff member to self-isolate.
 | Yes/No |