ttm Healthcare

Appendix 1: COVID-19 Healthcare Worker Relocation Self Risk Assessment

Name (print): _____ **Current Job title:** _____

Date of Birth: _____ **Mobile phone no:** _____

Moving from: _____ **Moving to:** _____

	Please Tick	
	Yes	No
1. Symptoms - within the past 14 days, have you experienced:		
• Fever/Chills/Sweating		
• Shortness of breath		
• New/Worsening cough		
• Sore throat		
• Malaise/Aches		
• Loss/distortion of taste or smell		
• Vomiting/Diarrhoea		
2. Recent possible exposure (within past 14 days) - workplace or other		
• Unprotected or protected contact with a confirmed or probable case		
• Advised to restrict your movement in the past 14 days		
• Advised to self-isolate in the past 14 days		
• Working under derogation in the past 14 days		
3. Travel/Relocation		
• Travel within 14 days from outside the island of Ireland, excluding 'Green List Countries'		
• Relocation from another region of the country		
• Moving from a healthcare service unit where there is one or more confirmed cases within the past 14 days, to another service		

1. If you have any of the symptoms listed in Section 1, please self-isolate and contact your existing GP for assessment and possible testing.
2. If you had contact (with or without appropriate Personal Protective Equipment) with a confirmed or probable case within 14 days before your start date please request testing. If you are restricting movement, self-isolating or working under a derogation please advise your Consultant that you are following HSE guidelines.
3. If you have travelled from countries outside the island of Ireland within 14 days before your start date, you must restrict movement for 14 days from the date of entry. Testing is not required unless you develop symptoms. As with the existing procedure regarding travelling to Non Green List Countries please adhere to the TTM Annual Leave process.
   See https://www2.hse.ie/conditions/coronavirus/travel.html.

If you have indicated yes to any of the above you are not permitted to attend shift. If you have any queries please contact your TTM Consultant.

Healthcare Worker Signature:_____ Date: _____