

Institute of
 Reproduction & IVF
 Director: Prof. Foad Azem

המכון לפרייון
 והפריה חוץ גופית
 מנהל: פרופ' פואד אזם

**Declaration Form for a Patient / Companion Regarding
 Exposure to the Coronavirus COVID-19**

Personal information / Label

First and last name: _____ ID: _____

Please fill in all these details if during the last two weeks you experienced:

Complaints	Fever <input type="checkbox"/>	Shivers <input type="checkbox"/>	Vomiting <input type="checkbox"/>
	Cough <input type="checkbox"/>	Headache <input type="checkbox"/>	Diarrhea <input type="checkbox"/>
	Sore throat <input type="checkbox"/>	Muscle pain <input type="checkbox"/>	Loss of smell/taste <input type="checkbox"/>
	Breathlessness <input type="checkbox"/>	Abdominal pain <input type="checkbox"/>	Other: _____
Active disease	Have you been diagnosed as a coronavirus COVID-19 carrier: Yes / No (if yes – date of the test _____)		
Stayed abroad during the last month	Yes / No		
Known exposure to a confirmed or suspected case of COVID-19 or any other infectious disease	Has one of your family members had a fever / runny nose / cough / sore throat or any kind of infection? Yes / No		
	Has someone you have been in contact with been in quarantine during the last two weeks? Yes / No		
	Have you been exposed to a confirmed / suspected corona patient? Yes / No If yes, what was the date of exposure: _____		

The State of Israel | Ministry of Health
TEL AVIV SOURASKY MEDICAL CENTER
LIS MATERNITY & WOMEN'S HOSPITAL
Affiliated to Tel Aviv University
Sackler School of Medicine



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המרכז הרפואי תל-אביב ע"ש סוראסקי
ביה"ח ליס לילודות ונשים
מסונף לפקולטה לרפואה ע"ש סאקלר
באוניברסיטת תל-אביב

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Sharing the details above will not prevent proper medical treatment.

I hereby declare that all the details noted above are true, and I am aware that concealing information is liable to pose a danger to public health and endanger the medical team.

Date: ___/___/___ Time: ___:___

Full name: _____ Signature: _____

טל': 03-6925610 | פקס: 03-6925687

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