Date………………………………………………..Time of call………………………………………………

SARC staff name……………………………………………………………Designation………………………………………………………………..

Complainant name……………………………………………….……… Date of birth……………………………….Age………………………

Police or self-referral

Police reference………………………………………………………………..SARC number………………………………………………………………….

Caller’s name……………………………………………………………….Caller’s designation ……………………………………………………

Contact telephone number and email (more than one if possible)………………………………………………………………..…

**Please advise complainant / referrer that a forensic medical examination cannot be organised until the following information is provided:**

|  |  |  |
| --- | --- | --- |
|  | **Complainant** | **Any person planning to accompany complainant** |
| 1. Have they had contact with a known or suspected COVID-19 positive person in the last 14 days? |  |  |
| 1. Do they have influenza like illness?   Fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing). |  |  |
| 1. Do they feel unwell? If so, how? |  |  |
| 1. When did they first have these symptoms? |  |  |
| 1. Have they contacted 111? When? |  |  |
| 1. If so, what was 111 advice? |  |  |
| 1. The above details have been provided by whom? |  |  |

Client name……………………………………………… SARC number……………………………………………………

These details need to be discussed with a Forensic Clinician

**Name of Forensic Clinician making decision**…………………………………………………

Discussion details:

Assign complainant to the following categories:

|  |  |
| --- | --- |
| 1. Asymptomatic and no apparent risk of COVID-19 |  |
| 1. Known COVID-19 or with symptoms suggestive of COVID-19 |  |

Decision after triage by Forensic Physician

|  |  |  |
| --- | --- | --- |
| **Option** | **Decision** | **Arrangements made are:** |
| Examination at SARC |  |  |
| Arrange for telephone consultation (police referral) |  |  |
| Arrange for telephone consultation (self-referral) |  |  |
| Client has COVID-19 or has symptoms suggestive of COVID-19 but requires face to face FME |  |  |
| Other |  |  |

Forensic Clinician name………………………………………………………GMC /NMC number……………………………..

Forensic Clinician signature…………..…………………………………………………………………..

Date and time………………………………………………………………………………………………………….