**RKI Empfehlungen für medizinisches Personal bei Kontakt zu   
COVID-19-Patienten** – Stand 24.03.2020

1. **Hohes Risiko**

**Wenn Kontakt zu Sekreten oder Aerosolen**

**nur** mit Mund-/Nasenschutz arbeiten

7 Tage Quarantäne

Ø Symptome

Symptome

**Testen!**  
PCR-Test  
PCR-Test

weitere 7 Tage Quarantäne

+

**Kontakt**

1. **Begrenztes Risiko**

**nur** mit Mund-/Nasenschutz arbeiten

mindestens  
1,5 - 2 Meter

15 Minuten

+

****

Täglich Symptome im Dokumentationsbogen eintragen.

Bei Krankheitssymptomen Arbeit **sofort** beenden und PCR-Test durchführen.

**Wenn Kontakt ohne Schutzausrüstung im Mindestabstand von 1,5 - 2 m zu COVID-19-Patienten   
oder 15 Minuten face-to-face-Kontakt mit o.g. Abstand**

**Kontakt**

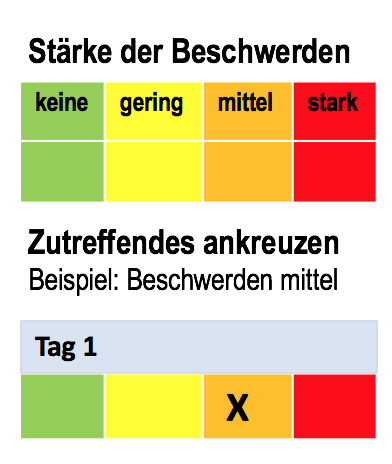
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**Dokumentationsbogen**

**Praxis Dr. Alexander Heinl**  
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Tel: 06131-674081 Fax: 06131-674082

E-Mail: [praxis.heinl@gmail.com](mailto:praxis.heinl@gmail.com)

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Startdatum der Dokumentation bitte hier eintragen:

Täglich dokumentieren!

Bei Verschlechterung bitte   
Verlaufsbogen an die Praxis mailen!

**Sofort mailen**, **wenn Husten, Atemnot und Fieber auftreten als starke Beschwerden.**

Wir melden uns!

|  |  |
| --- | --- |
| Nachname |  |
| Vorname |  |
| Alter |  |
| Rückruf-Telefonnummer |  |

|  |  |
| --- | --- |
| Kontakt zu positiv getesteten Personen? Wenn ja, wann? Datum: |  |
| Aufenthalt in einem Risikogebiet: Wenn a, von wann bis wann? |  |
| Und in welchem Risikogebiet: |  |
| Plötzlicher Beginn der Beschwerden – Wann? Bitte Datum angeben: |  |

**x**

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| Corona-Abstrich wurde durchgeführt? Wenn ja, bitte ankreuzen: |  |

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|  | | **Tag 1** | | | | | **Tag 2** | | | | | **Tag 3** | | | | | **Tag 4** | | | | | **Tag 5** | | | | | **Tag 6** | | | | | **Tag 7** | | | | | **Tag 8** | | | | | **Tag 9** | | | | | **Tag 10** | | | | | **Tag 11** | | | | | **Tag 12** | | | | | **Tag 13** | | | | | **Tag 14** | | | |
| **Stärke der Beschwerden** |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Gliederschmerzen |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Schnupfen |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Halsschmerzen |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| **Husten trocken** |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| **Husten mit Auswurf** |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| **Luftnot** |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| **Kurzatmigkeit** |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Müdigkeit |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Kopfschmerzen |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Durchfall |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Geschmacksstörung |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Geruchsstörung |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| **Körpertemperatur bitte messen & angeben** Fieber, wenn 37,8 rektal oder im Mund gemessen oder, 37,4 unter der Achsel. |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |  | | | | |

**Zutreffende Risikofaktoren unbedingt im hellblauen Feld ankreuzen:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Raucher |  |  | Diabetes |  |  | Bluthochdruck |  |  | Immunsuppressive Therapie |  |  | Atemwegserkrankungen |  |  | Alter über 60 |  |

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| Persönlicher Kontakt zu einem erkrankten Familienangehörigen |  |

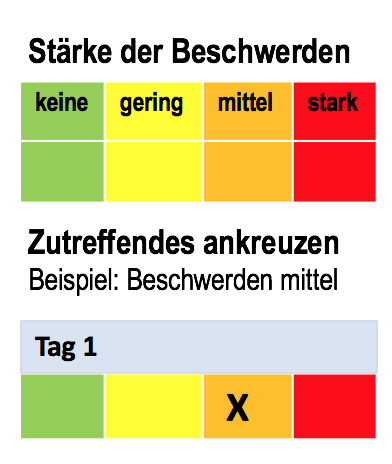
**Dokumentationsbogen**

|  |  |
| --- | --- |
| Nachname |  |
| Vorname |  |
| Alter |  |
| Rückruf-Telefonnummer |  |

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Täglich dokumentieren!

**x**

Bei Verschlechterung bitte Verlaufsbogen an die Praxis

mailen!

**Sofort mailen**, **wenn Husten, Atemnot und Fieber als starke Beschwerden auftreten.**

Wir melden uns!

**Nach Tag 28. den Verlaufsbogen unbedingt wieder an die Praxis mailen.**

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|  | | **Tag 15** | | | | | **Tag 16** | | | | | **Tag 17** | | | | | **Tag 18** | | | | | **Tag 19** | | | | | **Tag 20** | | | | | **Tag 21** | | | | | **Tag 22** | | | | | **Tag 23** | | | | | **Tag 24** | | | | | **Tag 25** | | | | | **Tag 26** | | | | | **Tag 27** | | | | | **Tag 28** | | | |
| **Stärke der Beschwerden** |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
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| Schnupfen |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
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| **Luftnot** |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
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| Durchfall |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
| Geschmacksstörung |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |
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