



Consent Form

Name:

Date:

1. Have you had any of the following symptoms in the last 14 days:

- a) A high temperature? (A high temperature can mean feeling hot to touch on your chest and back – you don't need to measure your temperature.) Yes No
- b) A new continuous cough? (This means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours – if you usually have a cough it may be worse than usual.) Yes No
- c) Loss of sense of smell or taste Yes No
- d) Shortness of breath: Yes No
- e) Runny nose or sore throat: Yes No
- f) A new rash Yes No

2. To the best of your knowledge have you been in close contact (under 2 meters) with anyone with confirmed COVID-19 in the last 14 days? Yes No

3. Have you:

- a) Recently travelled abroad and/or been instructed by the government to self-quarantine? Yes No
- b) Been contacted by NHS Track and Trace and told to self-isolate for any reason? Yes No

4. Are you currently:

- a) In the clinically extremely vulnerable category and therefore advised to shield at home? Yes No
- b) Do you live with someone who is?. Yes No

5. Have you been made aware of the guidelines that require a telephone/video triage appointment to be conducted before you attend in person? Yes No
6. Are you aware of the clinic's requirement for social distancing, hand sanitising and wearing a face-covering that does not contain a valve? Yes No
7. Have you been told the treatment room is cleaned before and after your attendance, and your therapist will be wearing PPE, as per public health guidelines? Yes No
8. Are you aware of the clinic's requirement for payment by card or bank transfer? Yes No
9. In line with government guidance, this clinic has implemented all the measures required to minimise the risk of Covid-19 transmission, however, as treatment will involve close contact within 1 metre, it will be impossible to completely eliminate risk. Please confirm that you understand this risk and are happy to proceed with the treatment. Yes No
10. Are you aware that you have the right to decline all or part of the treatment at any time? Yes No
11. Do you consent for the therapist to provide reports or information to your GP / consultant where they deem it in your health interests to do so? Yes No
12. Are you aware that all personal information will be confidential; it will be stored in a secure GDPR compliant cloud-based practice software programme and no information is given to third parties without consent? Yes No
13. Have you had the opportunity to ask all the questions you wish to, and have they been answered to your satisfaction? Yes No

Signed

Date:

(Patient)

OR

Signature of person with parental responsibility / person legally entitled to sign on behalf of a person who lacks capacity

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Date: