SUNNYSIDE CLINIC

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? And has your physiotherapist discussed and agreed with you the reasons why your clinical need for healthcare cannot be met by a telephone/video consultation. 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

…… Date: ……