SUNNYSIDE CLINIC

Consent Form

Name: Date:

1. Have you had any of the following symptoms in the last 14 days:
   a) A high temperature Yes ☐ No ☐
   b) A new continuous cough Yes ☐ No ☐
   c) Loss of sense of smell or taste Yes ☐ No ☐
2. To the best of your knowledge have you been in close contact with anyone with confirmed COVID-19 in the last 14 days? Yes ☐ No ☐
   a) Have you been instructed to self-quarantine, self-isolate or advised to shield at home? Yes ☐ No ☐
3. Have you been made aware of the guidelines that require a telephone/video triage appointment to be conducted before you attend in person for a new assessment? Yes ☐ No ☐
4. 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 ☐
5. 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 ☐
6. Are you aware of the clinic's requirement for payment by card? Yes ☐ No ☐
7. Are you aware that you have the right to decline all or part of the treatment at any time? Yes ☐ No ☐
8. 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 ☐

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 ☐

Signed …….. Date: ……

(Patient)

OR

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

…… Date: ……