

Screening Form

Name:

Contact Telephone Number:

About Me:

Have you had any of the following symptoms in the last 10 days: fever, shortness of breath, loss of sense of taste or smell, dry cough or sore throat? Yes No

Are you in the clinically extremely vulnerable category and therefore advised to shield at home by the government? Yes No

Have you, to the best of your knowledge, been in close contact with anyone with confirmed COVID-19 in the last 10 days? Yes No

Have you travelled abroad in the last 14 days? If 'yes' please state which country, you have visited? Yes No

Do you understand that coronavirus may not cause symptoms in some people and is currently causing a pandemic which means healthcare services are required to operate differently? Yes No

Have you been made aware of physiotherapy guidelines that require a telephone/video triage appointment to be conducted before you can attend in person? Yes No

About my Visit:

Are you aware of the clinic's requirement for social distancing / hand decontamination / face coverings & contactless payments in the clinic? Yes No

Have you been told about the cleaning of the clinic room before/after my attendance? Yes No

Do you understand that your physiotherapist is required to wear PPE as stated by Public Health authorities during your appointment? Yes No

About my Clinician:

Have they confirmed they have not had any of the following symptoms in the last 10 days: fever, shortness of breath, loss of sense of taste or smell, dry cough or sore throat? Yes No

Have they confirmed that to the best of their knowledge, they have not been in direct contact with anyone with confirmed COVID-19 in the last 10 days whilst not in full PPE? Yes No

Have they discussed with me the reasons why my clinical need for healthcare cannot be met by a telephone/video consultation? Yes No

Have you had the opportunity to ask all the questions you wish to, and all of my questions have been answered to my satisfaction? Yes No

This virus is considered to be at its most contagious up to three days before the patient has displayed any symptoms. Therefore, you the patient, may be at risk of contracting the virus from us, and us from you, despite the precautions we are taking.

Do you understand this risk and are you prepared to take this risk?

Yes

No

I agree to attend a face to face appointment during the COVID-19 pandemic.

Yes

No

Signed by Patient:

(or person with parental responsibility / person legally entitled to sign on behalf of a person)

Date:

Temp:.....

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:

I can confirm that the information I have provided is still accurate and correct:

Signed:

Date:

Temp:
