Physio Action

Screening Form

Name: ……. **Contact Telephone Number:** ……..

About Me:

Have you had the Covid-19 vaccination(s)? If so when? ……. Yes ☐ No ☐

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 ☐

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 10 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 read the physiotherapy guidelines on the Patient Journey on our website before this face to face appointment? 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**: ....

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