Appendix 15 – Paper consent form

Health information: Covid-19 consent form

Name
(please print)

Date

Covid-19 screening information

		Y	N
1	Have you had a fever in the last 7 days? (feeling hot to touch on your chest and back)	○	○
2	Do you now, or have you recently had, a persistent dry cough? (coughing a lot for more than an hour, 3 or more coughing episodes in 24 hours or worsening of a pre-existing cough)	○	○
3	Have you lost sensations of taste and smell?	○	○
4	Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms?	○	○
5	Have you been told to stay home, self-isolate or self-quarantine?	○	○
6	Do you or anyone that you live with fall into the 'clinically vulnerable' or 'clinically extremely vulnerable' categories as defined below?	○	○

Consent for treatment

I understand that, because my treatment may involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including Covid-19.

I give my consent to receive treatment from this practitioner.

I am the	**Patient** ○	***Parent/Guardian/Carer** ○	**Practitioner**
Name			
Signed			
Date			

***If you are signing on behalf of the patient, or if the patient is a minor, please state your relationship with the patient below:**

I am the patient's