Appendix 15 – Paper consent form

Health information: Covid-19 consent form

Name
(please print)

Date:

Covid-19 screening informtion

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-esistion cough.)

3 **Have you lost sensations of tast 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 -isolat 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?**

Y N

Consent for treatment

I understand that, becausse my treatment may involve touh and closse phisical 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 prcatitioner:

I am the:

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:**