

# Health information: Covid-19 consent form

Name  
(please print)

Date:

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## Covid-19 screening information

1 Have you had a fever in the last 7 days?

(Feeling hot to touch on your chest and back.)

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

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.)

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

3 Have you lost sensations of taste and smell?

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

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?

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

5 Have you been told to stay home, self-isolate or self-quarantine?

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

6 Do you or anyone that you live with fall into the 'clinically vulnerable' or 'clinically extremely vulnerable' categories as defined below?

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

## 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 <input type="checkbox"/>	Parent/Guardian/carer <input type="checkbox"/>	Practitioner
Name:	<input type="text"/>		
Signed:	<input type="text"/>		
Date:	<input type="text"/>		

\*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