Health information: Covid-19 consent form

Name (Please Print)	
Date of Appointment	
Time of Appointment	

Covid-19 screening information

		YES	NO
1	Have you had a high temperature? (this can mean 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 4 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 6 ‘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**	**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	