POSITIVE STEPS
PHYSIOTHERAPY

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COVID-19 Screening & Consent Form

Name	
Address	
Date of Birth	

About me:

I confirm that I have not had any of the following symptoms in the last 14 days: fever, shortness of breath, loss of sense of taste or smell, dry cough.

Yes ☐ No ☐

I confirm that to the best of my knowledge, I have not been in close contact with anyone with confirmed COVID-19 in the last 14 days.

Yes ☐ No ☐

I 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 ☐

I confirm I have been made aware of physiotherapy guidelines that require a telephone/video triage appointment to be conducted before the appointment takes place.

Yes ☐ No ☐

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About my visit:

I confirm I am aware of the requirement for social distancing whenever possible.

Yes ☐ No ☐

I confirm I am aware of the requirement for hand decontamination prior to and after my visit:

Yes ☐ No ☐

I confirm I am aware it is preferable for me to wear a face-covering whilst my visit takes place[1]:

Yes ☐ No ☐

I understand that my physiotherapist is required to wear PPE as set by Public Health authorities during my appointment and this is not optional for them.

Yes ☐ No ☐

About my Clinician:

They have confirmed they have not had any of the following symptoms in the last 14 days: fever, shortness of breath, loss of sense of taste or smell, dry cough:

Yes ☐ No ☐

They have confirmed that to the best of their knowledge, they have not been in close contact with anyone with confirmed COVID-19 in the last 14 days.

Yes ☐ No ☐

They have discussed with me the reasons why my clinical need for healthcare cannot be met by a telephone/video consultation.

Yes ☐ No ☐

[1] Exemptions to wearing face masks may apply.

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I am aware that if my clinician is contacted by Track and Trace they may need to disclose some of my personal information.

Yes ☐ No ☐

I have had the opportunity to ask all the questions I wish to, and all of my questions have been answered to my satisfaction. Use space below to record details:

I agree to a face to face appointment during the COVID-19 pandemic.

Yes ☐ No ☐

Signed Patient ……..

OR [delete as applicable]

Signature of person with parental responsibility / person legally entitled to sign on behalf of a person who lacks capacity

……

Signed Therapist……  ……

Date: ……