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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 known COVID-19 symptoms in the last 14 days.

Yes ⬜ No ⬜

I confirm that if I have been in close contact with anyone with confirmed COVID-19 in the last 14 days I will carry out a lateral flow test prior to my appointment and have a negative result.

Yes ⬜ No ⬜

I understand that coronavirus may not cause symptoms in some people and is currently causing a pandemic which means healthcare services to send screening questionnaires

Yes ⬜ No ⬜

## About my visit:

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

Yes ⬜ No ⬜

I understand that my physiotherapist is required to risk assess and may need to wear PPE as set by National infection prevention and control (IPC) guidance during my appointment and if deemed necessary this is not optional for them.

Yes ⬜ No ⬜

## About my Clinician:

They have confirmed they have not had any of the known COVID-19 symptoms in the last 14 days.

Yes ⬜ No ⬜

Please use the space below to record any questions you may have:

I agree to a face to face appointment.

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: …………………**