Health information: Covid-19 consent form

A. Covid-19 screening information

Question	Yes	No
1. Have you had a fever in the past 7 days?	☐	☐
2. Do you have now or have had recently a persistent dry cough? (Definition: coughing a lot for more than an hour and/or 3 or more coughing episodes within 24 hours and/or worsening of a pre-existing cough)	☐	☐
3. Have you lost any ability to taste or smell in the past week?	☐	☐
4. Have you been in contact with anyone in the past 14 days who has been diagnosed with Covid-19 or has the above coronavirus-type symptoms?	☐	☐
5. Have you been told to self-isolate or quarantine?	☐	☐
6. Do you or anyone that you live with fall into a "clincally vulnerable" category? (You/the other person will have been informed of this by the GP)	☐	☐

B. Consent for treatment

- I understand that, because my treatment involves 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

Name (please print)	
Signed	Date
Clinical justification (completed by practitioner	T°C on arrival