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COVID-19 Screening questionnaire

Personal Details

Name: _____

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, runny nose or sore throat.

Yes ☐ No ☐

I **confirm** that I am not in the clinically extremely vulnerable category and therefore advised to shield at home by the government.

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 I can attend in person.

Yes ☐ No ☐

About my visit

I confirm I am aware of the clinic's requirement for **social distancing** in the clinic.

Yes ☐ No ☐

I confirm I am aware of the clinic's requirement for **hand decontamination** as I enter the clinic:

Yes ☐ No ☐

I confirm I am aware if the clinic requires me to wear a **face-covering** whilst inside the clinic:

Yes ☐ No ☐

I confirm I have been told about the **cleaning** of the clinic room before/after my attendance:

Yes ☐ No ☐

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I confirm I am aware of the clinic's requirement for **contactless payment**

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, runny nose or sore throat:

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 ☐

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

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

Yes ☐ No ☐

Patient signature _____

OR [delete as applicable] signature of person with parental responsibility/person legally entitled to sign on behalf of a person who lacks capacity

Signature _____

Signed Therapist _____

Date: _____

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