Please print and fill in
Personal Details

Name:

Address:

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 ☐

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 in the clinic:

Yes ☐ No ☐

I confirm I am aware if the clinic requires me to wear a face-covering whilst inside the clinic[1]:

Yes ☐ No ☐

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

Yes ☐ No ☐

I understand that my therapist 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 ☐

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:

[11] Exemptions to wearing face masks may apply.

I agree to attend 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: ……