



Health information: Covid-19 consent form

Name

Today's date

Date of birth

Covid-19 screening information

	Y	N
1 Have you had a fever in the last 7 days? (high readings or hot to touch on chest and back)	<input type="checkbox"/>	<input type="checkbox"/>
2 Do you now, or have you recently had a persistent dry cough? (coughing a lot for more than an hour or 3 or more coughing episodes in 24 hours or a worsening of a pre-existing cough)	<input type="checkbox"/>	<input type="checkbox"/>
3 Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
4 Have you been told to self-isolate/self-quarantine for any reason including travel abroad?	<input type="checkbox"/>	<input type="checkbox"/>
5 Do you have any other symptoms that may mean you have a Covid-19 infection? (loss of taste and smell, unusual fatigue or shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>

People at high risk (clinically extremely vulnerable)*

Please select **Y** if **any** of the following apply to you:

- had an organ transplant
- having chemotherapy or antibody treatment for cancer, including immunotherapy
- having an intense course of radiotherapy (radical radiotherapy) for lung cancer
- having targeted cancer treatments that can affect the immune system (such as protein kinase inhibitors or PARP inhibitors)
- have blood or bone marrow cancer (such as leukaemia, lymphoma or myeloma)
- had a bone marrow or stem cell transplant in the past 6 months, or still taking immunosuppressant medicine
- told by a doctor that you have a severe lung condition (such as cystic fibrosis, severe asthma or severe COPD)
- have a condition that means you have a very high risk of getting infections (such as SCID or sickle cell)
- taking medicine that makes you much more likely to get infections (such as high doses of steroids)
- pregnant and have a serious heart condition

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

*If you select **Yes** after reading this list, you are classed as **clinically extremely vulnerable** and the government may advise that you exercise '**shielding**' at different stages of the pandemic. (Government advice stated that for your protection and until 30 June 2020, you should stay at home at all times and avoid face-to-face contact with anyone outside your own household).

People at moderate risk (clinically vulnerable)

Y	N
<input type="checkbox"/>	<input type="checkbox"/>

Please select **Y** if **any** of the following apply to you:

- 70 or older
- pregnant
- have a lung condition that is not severe (such as asthma, COPD, emphysema or bronchitis)
- have heart disease (such as heart failure)
- have diabetes
- have chronic kidney disease
- have liver disease (such as hepatitis)
- have a condition affecting the brain or nerves (such as Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy)
- have a condition that means you have a high risk of getting infections
- taking medicine that can affect the immune system (such as low doses of steroids)
- very obese (BMI of 40 or above)

If you select **Yes** after reading this list, you are at **moderate** risk from coronavirus and it is very important you follow the advice on social distancing.

Consent for treatment

I declare that the information I have provided is correct to the best of my knowledge. I understand that because my treatment may involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including Covid-19, despite the institution of new social distancing, hygiene, hand-washing and PPE procedures.

I consent to the practitioner retaining the details provided on this form for a period of 7 years from today. I further understand that if I am under 18 years of age, these records will be kept until I reach the age of 25 (7 years after reaching 18).

In the eventuality that the practitioner get symptoms of COVID-19 within 48 hours of having close contact with me during the appointment and then later tests positive, I understand that they are obligated under law to provide my name, phone number or email, and the date and time of my visit to the test and trace service. I note that by attending the appointment I give consent for this.

I give my consent to receive treatment from this practitioner.

I am the	Patient <input type="checkbox"/>	*Parent/Guardian/Carer <input type="checkbox"/>	Practitioner
Name			
Signed			
Date			

***If you are signing on behalf of the patient, or if the patient is a minor, please state your relationship with the patient below:**

I am the patient's