Health information: Covid-19 consent form

|  |  |
| --- | --- |
| Name  **(please print)** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s date |  |  |  |  |  |  |  |  | Date of birth **(if under 18 years)** |  |  |  |  |  |  |  |  |

Covid-19 screening information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | **Y** |  | **N** |
| **1** | Have you had a fever in the last 7 days? **(feeling hot to touch on your chest and back)** |  |  |  |  |  |
|  |  |  |  | | | |
| **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)** |  |  |  |  |  |
|  |  |  |  | | | |
| **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? |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  | | | |
| **4** | Have you been told to stay home, self-isolate or self-quarantine? |  |  |  |  |  |
|  |  |  |  | | | |
| **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)** |  |  |  |  |  |
|  |  |  |  |  |  |

| People at high risk (clinically extremely vulnerable)\* |  | |  | |  | | **Y** | |  | | **N** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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

\*If you select **Yes** after reading this list, the practitioner should explain that you are classed as **clinically extremely vulnerable** and the government advise that you exercise ‘**shielding’**. Current government advice says 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** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 and 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.

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).

**I give my consent to receive treatment from this practitioner.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| I am the | **Patient** |  | **\*Parent/Guardian/Carer** |  | **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 |  |