Physio@Home

COVID-19 Consent form

Personal Details

Name:

Address:

About Patient:

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 O No O

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

Yes O No O

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 O No O

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 O No O

About my Visit:

I confirm I am aware of the requirement for hand decontamination during the session:

Yes O No O

I confirm I have been told about the cleaning of any equipment before/after my session:

Yes O No O

I confirm I am aware of the requirement for contactless payment

Yes O No O

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 ○

I have had the opportunity to ask all the questions I wish to, and all of my questions have been answered to my satisfaction.

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

Yes ○ No ○

Signed Patient ………………………………………………………………………..

OR [delete as applicable]

Signature and printed name of next of kin if patient unable to sign

…………………………………………………………………………………………….

Signed Therapist……………………………………………………………………….

Date: …………………