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 Covid-19
Client Screening and Consent

**Full Name**:

**Address:**

**Post code:**

**Email address**:

**Mobile number**:

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| --- | --- |
| Please answer the following questions |  Yes / No |
| Have you had a Covid-19 test? If yes when? Antigen (tests for Covid on DAY of testing) or Antibody (tests for possible immunity) |  |
| If it was positive, has the isolation period expired?If not you cannot book an appointment until after the isolation date |  |
| Do you still have any symptoms? |  |
| Do you have a new or persistent cough? |  |
| Do you have a temperature above 37.8 degrees C |  |
| Have you lost or are you experiencing any loss of smell or taste? |  |
| Have you been in contact with anyone with Covid-19 symptoms or been living in a household with someone who is self-isolating due to Covid-19 symptoms?If YES please self-isolate for 14 days. |  |
|  |  |
| Please inform the therapist if you have any of the following as it might affect the level of PPE worn.  |  |
| * Recently been hospitalised
* High blood pressure or other heart condition
* Diabetes
* Cancer
* Respiratory conditions
* Aged over 70
* Pregnant, no of weeks

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|  |  |
| **Previously contracted Covid-19**Are you experiencing post-Covid-19 circulatory complications? DVT, micro-embolisms, stroke symptoms, pulmonary embolism or even new skin rashes/blisters |  |
| Are you an NHS front line worker, carer either home or care home setting or shielding a vulnerable person?  |  |
|  |  |
| Are you allergic to latex gloves or specific cleaning products? |  |

I declare that the information I have provided is true and correct and I conscientiously believe the same to be true. I am aware that if I give false information and someone were to be harmed as a result then I could be prosecuted for making a false declaration.

If either I, or someone I have been in close contact with tests positive within 7 days of the appointment or I am contacted by NHS Track and Trace then I will inform you.

**Signature**: **Date**:

**Full name**: