STANSFIELD
SPORTS INJURY
CLINIC

Covid- 19 Informed Consent & Screening for a Face to Face Appointment

Title Mr/Mrs/Miss/other: First Name:

Surname: Date of Birth:

Address:

Post Code: Contact Telephone:

Email:

Covid- 19 Screening

Have you ever had a COVID- 19 test, this includes PCR, Antigen and Antibody tests? Y [ ] N [ ]

If you answered yes, please state the date of test/results: _____

Was the test Positive? Y [ ] N [ ] Unclear [ ]

If you tested positive, did you follow a period of quarantine? Y [ ] N [ ]

Please comment: _____

Have you been adhering to social distancing measures: Y [ ] N [ ]

How do you feel today:

I feel physically normal [ ] (If ticked please move to next section)

I feel unwell [ ] (If ticked please inform your Clinician. It will be advised that if you have symptoms of Covid- 19 you will be unable to attend your face to face appointment today, for a minimum period of 14 days and only if you then feel well).

In the last 14 days have you had any of the following symptoms:

New continuous cough Y [ ] N [ ]

(A new cough that's lasted for an hour/ have had 3 or more episodes of coughing in 24 hours/ are coughing more than usual)

Temperature/ Fever above 37.8 C or greater Y [ ] N [ ]

Loss of/ change in sense of smell or taste Y [ ] N [ ]

Shortness of breath Y [ ] N [ ]

Runny nose Y [ ] N [ ]

To the best of my knowledge, I have not been in contact with anyone with **confirmed** Covid- 19 Y [ ] N [ ]

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(If you have answered Yes to any of the above you will be unable to attend your face to face appointment today, until you have either completed a Coronavirus test that is negative, or followed a period of quarantine)

High Risk and Shielding Individuals

Do you fall into a high risk or shielding group Y [ ] N [ ]

(If you have answered No, please move onto the next section)

Please tick below if you fall into any of the following high risk groups:

Aged above 70 [ ]

Under 70 and instructed to get an annual Flu jab on medical grounds [ ]

Pregnant [ ] Diabetes [ ] Chronic Respiratory Disease [ ] Chronic Heart Disease [ ]

Chronic Kidney Disease [ ] Chronic Liver Disease [ ] Chronic Neurological Condition [ ]

Spleen conditions [ ] BMI above 40 [ ]

Weakened Immune System due to HIV/Aids [ ]

Weakened Immune System due to medications such as Steroids or Chemotherapy [ ]

Further information: _____

_____

Extremely High Risk Individuals

Do you fall into an extremely high risk group Y [ ] N [ ]

(If you have answered No, please move onto the next section)

Please tick below if you fall into any of the following high risk groups:

Severe Chest and Lung Conditions such as Cystic Fibrosis/Severe Asthma/ COPD [ ]

Removed/absent Spleen [ ]

Significant Heart Disease & Pregnant [ ]

Solid Organ Transplant [ ]

Active Cancers [ ]

Immunotherapy/Antibody treatments for Cancer [ ]

**** If you have answered YES to any of the High Risk Group please discuss with your Clinician if a face to face appointment is necessary. It is at your own risk to continue with a face to face appointment in the current Covid 19 pandemic.

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**** If you have answered YES to any of the Extremely High Risk Group it is NOT advised that you attend a face to face appointment until further notice with the current Covid- 19 Pandemic.

Expectations of a face to face appointment

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 Y [ ] N [ ]

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

I understand that I have been made aware of a change of clinical practice during the pandemic, and that my Clinician will be wearing a mask and visor, apron and gloves during my treatment as set by Public Health authorities Y [ ] N [ ]

I understand that I may receive less/ minimal/ no hands on therapy if not necessary or appropriate during my appointment Y [ ] N [ ]

I confirm I have been made aware of the change in practice before my scheduled appointment, to allow me time to cancel my appointment or seek any additional information I require Y [ ] N [ ]

I confirm I am aware of the Clinic's hand sanitisation on entry and exit and that I may be asked to wear a face mask. I will also maintain social distancing of 1 metre + where able Y [ ] N [ ]

I confirm I am aware of the Clinic's requirement for contactless payment Y [ ] N [ ]

I have had the opportunity prior to my appointment to ask my Clinician any questions I feel necessary

Y [ ] N [ ]

I agree to a face to face appointment for myself or my child Y [ ] N [ ]

Signed:_____ Date: _____

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