BBA Covid-19 Triage Screening Questionnaire and Treatment Consent form

According to the guidelines from Acupuncture Society and Public Health England GOV.UK Dear Sir/ Madam,

It is very important for all of us to do everything to prevent Coronavirus (COVID-19) from spreading.

In order to assess the risk of treating please complete this questionnaire prior to treatment and sign it.

First Name ……………………………………………

Last Name……………………………………………..

Address…………………………………………………

………………………………………………………………...

……………………………………………………………….

Ph. no…………………………………………………..

Email……………………………………

S.No	Questions	Yes	No
1	Have you had a high-temperature fever in the last 7 days?		
2	Do you now, or have you recently had, a persistent dry cough or 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 Corona virus-type symptoms?		
4	Have you been told to stay home, self-isolate or self-quarantine or been contacted by the GOV.UK Track and trace app in the last 14 days?		
5	Do you have loss of taste and smell, unusual fatigue or shortness of breath?		
6	Have you had any of the following symptoms in the last 24 hrs -common cold ,runny nose, (dry) cough, sneezing, sore throat -loss of smell or taste		
	• Fever (38 degree or more)		
	• Red or sore eyes		
	• Tiredness		
	• Headache		
	• Feeling ill with or without diarrhoea		
7	Are there members of your family or household who have or had shortness of breath or fever within the past 14 days?		
8	Have you travelled abroad/or been asked to quarantine by the govt.or NHS?		
9	Are you classified as a vulnerable or an extremely vulnerable person		
10	Have you received vaccination for Covid 19? If yes how many shots?		

Patient Consent for treatment:

I understand that, because my treatment may involve close contact with my practitioner, there may be an elevated risk of disease transmission, including Covid-19.The practitioner has explained about all the COVID hygiene precautions and protocols in detail, that are being followed in the practice to reduce the risks.

I give my consent to receive treatment from this practitioner.

In the eventuality that I (the practitioner) get symptoms of Covid-19 within 48 hours of having close contact with you during the appointment and then later test positive, I am obligated under law to provide your name, phone number or email, and the date and time of your visit to the test and trace service. Please note that by attending the appointment you give consent for this.

Yes/No Signed ________________________

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 ________________

For Practitioner to fill in:

I have explained COVID hygiene and safety protocols to this client and have asked the triage questions. I am satisfied that it is safe to treat this client at this clinic.

Signed………………………………...

Date …………………………………...