Pre appointment assessment

Please complete and return this form **no more than 24 hours prior to your appointment**. Please contact me if you have any questions. I will be unable to see you if this form is not returned! Thankyou for your understanding.

Your Name:

Date completing Form: **Date of appointment**:

PLEASE COMPLETE THIS QUESTIONNAIRE

1) **Are you or anyone you live with in the high risk group (clinically extremely vulnerable)? ☐NO ☐YES**

2) **Are you or anyone you live with in the moderate risk group (clinically vulnerable)? ☐NO ☐YES**

If you are on the clinically extremely vulnerable or the clinically vulnerable list we must ascertain that the benefits of attending an appointment outweigh any risks it might pose. The same applies to anyone you live with.

3) **Taking into account any risks to yourself or anyone you live with do you consider this appointment essential? ☐NO ☐YES**

Screening for COVID-19 symptoms

1. Have you experienced ANY of the following symptoms within the last 14 days?
    a. Temperature or feeling feverish
    b. New cough
    c. Sore throat
    d. Shortness of breath
    e. Flu-like symptoms such as fatigue or headache
    f. Nausea or Diarrhoea
    g. Chills or shivering
    h. Muscle pain or rash
    i. Loss of taste OR smell

    ☐NO ☐YES ***If yes to any your appointment must be postponed.***

2. Have you been exposed, diagnosed or suspected of having COVID-19 in the last 14 days? ☐NO ☐YES

3. Have you been tested? ☐NO ☐YES

4. Please provide date:

5. Was the result: Positive ☐ or negative ☐

Please do not attend an appointment if :

- **You are currently isolating.**
- **A family member or close contact has CV 19 symptoms, a positive CV19 diagnosis or isolating.**
- **You, a family member, or close contact have travelled internationally in the last 15 days.**

If you become unwell with COVID-19 symptoms on the day or your appointment, please DO NOT attend. No charge will be made for your missed appointment.

All possible steps have been taken to reduce the risks of transmission of COVID-19, however a level of risk will always remain.

Please see accompanying documents:

- Guidelines for attending your appointment during COVID-19
- COVID-19 Policy
- GDPR – Your privacy and data protection agreement (please check and re-submit)

COVID-19 risk assessments are available by visiting www.elementalhealth.net/COVID-19

Client Consent for Treatment During COVID-19 Pandemic

I understand that I am opting for an elective consultation/treatment/procedure.

I understand that the novel coronavirus, the World Health Organization has declared COVID-19, a worldwide pandemic and that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and as a result, social distancing is recommended. This is not entirely possible with my proposed treatment, however, I am satisfied that safety measures are in place to minimise risk as much as possible, and patient contact will be kept to an absolute minimum in line with medical need.

I understand the Management and Clinical Staff are closely monitoring the COVID-19 situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective consultation/ treatment/procedure, and I give my express permission to proceed.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I understand that COVID-19 can cause additional health risks, some of which may not currently be known at this time, in addition to those risks associated with the consultation/ treatment/procedure itself.

I have been given the option to defer my medical consultation/treatment/procedure to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure.

I confirm that if I develop COVID-19 symptoms within 14 days following my treatment/procedure or a known contact of mine develops symptoms, I will immediately inform the practitioner to enable appropriate measures to be put in place and contact tracing to commence.

I am confirming that I have read the following documents, I am fully aware of their contents and agree to comply:

- Guidelines for attending your appointment
- COVID-19 Policy

Returning this form confirms that you have provided accurate information and consent to treatment in line with all the above statements. You will receive a text or email message for each subsequent appointment to check that details are unchanged. By signing you are confirming that these will be responded to.

Patient name: Signature:

Date:

Return to: elementalhealth.mail@gmail.com **Tel: 07931 222414** **www.elementalhealth.net**