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**PRE -APPOINTMENT WELLNESS SCREENING CHECKLIST**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please answer these questions as honestly as you can for the safety of you and your practitioner** | | | | | | | | | | | | |  | | | |  | | | | | | |
|  | | | |  | | | | | | |
| Patient Name | |  | | | | DOB | |  | | |  | | |  | |
| **Have you experienced ANY of the following symptoms within the last 14 days?** | | | | | | | | | | | | | | | | | | | | | | |
| Temperature of over 37.5°C or feeling feverish | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| New cough | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| Sore throat | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| *Shortness of breath* | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| *Flu-like symptoms such as fatigue, headache* | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| *Nausea or Diarrhoea* | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| *Chills or shivering* | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| *Muscle pains or rash* | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| *Loss of taste OR smell* | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | |
| Have you been exposed, diagnosed or suspected of having COVID-19 in the last 14 days | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| Have you had a throat and nasal swab? | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| Did you test Positive or Negative? | | | | | | | | | | | | | Positive | | | |  | | Negative | | |  |
| What was the date of the test? | | | | | | | | | | | | |  | | | | | | | | | |
| Have you had an antibody blood test? | | | | | | | | | | | | | YES | | | |  | | NO | | |  |
| Was it Positive or Negative? | | | | | | | | | | | | | Positive | | | |  | | Negative | | |  |
| What was the date of the test? | | | | | | | | | | | | |  | | | | | | | | | |
| **Family and close contacts** | | | | | | | | | | | | | | | | | | | | | | |
| Are any of your family members or immediate/close contacts currently sick or experiencing: Fever, Cough, Shortness of breath or Flu-like symptoms? | | | | | | | | | | | | | YES | | | |  | NO | | | |  |
| Are any of your family members or immediate/close contacts currently sick or experiencing: Sore throat, Muscle aches, Fatigue, Nausea & Diarrhoea? | | | | | | | | | | | | | YES | | | |  | NO | | | |  |
| Have any of your family members or immediate/close contacts been diagnosed with COVID-19? If yes, when? | | | | | | | | | | | | |  | | | | | | | | | |
| **Recent travel** | | | | | | | | | | | | |  | | | | | | | | | |
| Have you recently travelled internationally, travelled within the UK or attended a public event in the last 15 days? If yes, where and when? | | | | | | | | | | | | |  | | | | | | | | | |
| Has any of your family or close contacts recently travelled internationally, travelled within UK or attended an event in the last 15 days? If yes, where and when? | | | | | | | | | | | | |  | | | | | | | | | |
| PATIENT NAME (PRINT) | | | | |  | | | | | | | | | | | | | | | | | |
| PATIENT SIGNATURE: | | | |  | | | | | | Date: | | |  | | | | | | | | | |
| People at high risk (clinically extremely vulnerable)\* | | | | | | | | | | | | | | | | | | | | | | |
| Please select **Y** if **any** of the following apply to you: | | | | | | | | | | | | | YES | |  | | | | | NO |  | |
| * had an organ transplant * having chemotherapy or antibody treatment for cancer, including immunotherapy * having an intense course of radiotherapy (radical radiotherapy) for lung cancer * having targeted cancer treatments that can affect the immune system (such as protein kinase inhibitors or PARP inhibitors) * have blood or bone marrow cancer (such as leukaemia, lymphoma or myeloma) * had a bone marrow or stem cell transplant in the past 6 months, or still taking immunosuppressant medicine * told by a doctor that you have a severe lung condition (such as cystic fibrosis, severe asthma or severe COPD) * have a condition that means you have a very high risk of getting infections (such as SCID or sickle cell) * taking medicine that makes you much more likely to get infections (such as high doses of steroids) * pregnant and have a serious heart condition | | | | | | | | | | | | |  | |  | | | | |  |  | |
| \*If you select **Yes** after reading this list, the practitioner should explain that you are classed as **clinically extremely vulnerable** and the government advise that you exercise ‘**shielding’**. Current government advice says that for your protection and until 30 June 2020, you should stay at home at all times and avoid face-to-face contact with anyone outside your own household. | | | | | | | | | | | | | | | | | | | | | | |
| **Data Privacy Notice**:  This declaration will be retained confidentially until; it is superceded by a subsequent declaration by you; or the UK Government lifts COVID-19 restrictions, when it will be destroyed.  I am collecting and processing this personal data on the basis of Article 6(1)(f) and Article 9(2)(i) Regulation (EU) 2016/679 (“GDPR”) and Data Protection Act 2018 being necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care.  I do this as a preventive measure for our community to mitigate the risk of COVID-19 spreading.  This data sheet will be stored confidentially and is not shared with any third party, unless there is an official request by the local authorities, or the Government, for reasons of public interest in the area of public health or by law. | | | | | | | | | | | | | | | | | | | | | | |
| **Additional Patient Consent for Treatment During COVID-19 Pandemic** | | | | | | | | | | | | | | | | | | | | | | |
| **I** |  | | | | | | | | (patient name) understand that I am opting for an | | | | | | | | | | | | | |
| elective medical 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. | | | | | | | | | | | | | | | | | | | | | | |
| (initials) | | | | | | | | | | | | | | | | | | | | | | |
| I understand the 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/medical treatment/procedure, and I give my express permission to proceed. | | | | | | | | | | | | | | | | | | | | | | |
| (initials) | | | | | | | | | | | | | | | | | | | | | | |
| 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 medical consultation/ treatment/procedure itself. | | | | | | | | | | | | | | | | | | | | | | |
| (initials) | | | | | | | | | | | | | | | | | | | | | | |
| I have been given the option to defer my 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 medical treatment/procedure | | | | | | | | | | | | | | | | | | | | | | |
| (initials) | | | | | | | | | | | | | | | | | | | | | | |
| I confirm that I am not presenting with any of the following symptoms of COVOID-19 listed below:   * Fever * Shortness of Breath * Loss of Sense of Taste or Smell * Dry Cough * Runny Nose * Sore Throat | | | | | | | | | | | | | | | | | | | | | | |
| (initials) | | | | | | | | | | | | | | | | | | | | | | |
| I understand that air travel significantly increases my risk of contracting and transmitting the COVID­19 virus. I confirm that I have not travelled in the past 15 days | | | | | | | | | | | | | | | | | | | | | | |
| (initials) | | | | | | | | | | | | | | | | | | | | | | |
| I confirm that if I develop COVID-19 symptoms following my medical consultation/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 | | | | | | | | | | | | | | | | | | | | | | |
| (initials) | | | | | | | | | | | | | | | | | | | | | | |
| Patient name | | |  | | | | Practitioner name | | | | | Kate Kotlarska | | | | | | | | | | |
| Signature | | |  | | | | Signature | | | | | Kate Kotlarska | | | | | | | | | | |
| Date | | |  | | | | Date | | | | | 09/06/2020 | | | | | | | | | | |