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**PRE -APPOINTMENT WELLNESS SCREENING CHECKLIST**

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| **Please answer ALL highlighted questions as honestly as you can** |  |  |
|  |  |
| 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? | YES |  | NO |  |
| **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? | YES |  | NO |  |
| 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? | YES |  | NO |  |
| PATIENT NAME (PRINT) |  | PATIENT SIGNATURE |  | DATE |  |
| **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 Test, Track and Trace to commence. |
|  (initials) |
| Patient name |  | Practitioner name | Kate Kotlarska |
| Signature |  | Signature | Kate Kotlarska |
| Date |  | Date | 11/02/2022 |