

Health information: Covid-19 consent form

Name (please print)

Today's date Date of birth (if under 18 years)

Covid-19 screening information

- | | Y | N |
|--|--------------------------|--------------------------|
| 1 Have you had a fever in the last 7 days? (feeling hot to touch on your chest and back) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Do you now, or have you recently had, a persistent dry cough? (coughing a lot for more than an hour or 3 or more coughing episodes in 24 hours or a worsening of a pre-existing cough) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Have you been told to stay home, self-isolate or self-quarantine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Do you have any other symptoms that may mean you have a Covid-19 infection? (loss of taste and smell, unusual fatigue or shortness of breath) | <input type="checkbox"/> | <input type="checkbox"/> |

People at high risk (clinically extremely vulnerable)*

Please select **Y** if **any** of the following apply to you:

- | | Y | N |
|--|--------------------------|--------------------------|
| <ul style="list-style-type: none"> 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 | <input type="checkbox"/> | <input type="checkbox"/> |

*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.



British Acupuncture Council Member

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People at moderate risk (clinically vulnerable)

Please select **Y** if **any** of the following apply to you:

- | | Y | N |
|--|--------------------------|--------------------------|
| <ul style="list-style-type: none"> 70 or older pregnant have a lung condition that is not severe (such as asthma, COPD, emphysema or bronchitis) have heart disease (such as heart failure) have diabetes have chronic kidney disease have liver disease (such as hepatitis) have a condition affecting the brain or nerves (such as Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy) have a condition that means you have a high risk of getting infections taking medicine that can affect the immune system (such as low doses of steroids) very obese (BMI of 40 or above) | <input type="checkbox"/> | <input type="checkbox"/> |

If you select **Yes** after reading this list, you are at **moderate** risk from coronavirus and it is very important you follow the advice on social distancing.

Consent for treatment

I declare that the information I have provided is correct to the best of my knowledge and I understand that, because my treatment may involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including Covid-19.

I consent to the practitioner retaining the details provided on this form for a period of 7 years from today. I further understand that if I am under 18 years of age, these records will be kept until I reach the age of 25 (7 years after reaching 18).

I give my consent to receive treatment from this practitioner.

I am the	Patient <input type="checkbox"/>	*Parent/Guardian/Carer <input type="checkbox"/>	Practitioner
Name	<input type="text"/>		<input type="text"/>
Signed	<input type="text"/>		<input type="text"/>
Date	<input type="text"/>		<input type="text"/>

***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