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COVID-19 Questions for Patients Consenting to Therapeutic Treatments

Have you returned from overseas in the last 14 days? ☐ YES ☐ NO

Are you currently in quarantine or self-isolation for COVID19? ☐ YES ☐ NO

Have you had recent contact with a known or suspected COVID-19 case in the past two weeks? ☐ YES ☐ NO

Do you reside in or have you visited a known high-risk area with a cluster of cases? ☐ YES ☐ NO

Have you recently tested for COVID-19? ☐ YES ☐ NO

Date: **Result:**

Have you had any of the following symptoms?

Temperature > 38°C ☐ YES ☐ NO

A cough ☐ YES ☐ NO

A sore throat ☐ YES ☐ NO

Shortness of breath ☐ YES ☐ NO

Other respiratory symptoms ☐ YES ☐ NO

A recent loss of sense of smell ☐ YES ☐ NO

Patient Consent for Disclosure of Personal Information

I agree to my name and contact details being provided by my practitioner to the health authorities and other relevant parties for COVID 19 contact tracing purposes where this is deemed necessary.

I have the right to withhold permission but understand that treatment would not proceed. I acknowledge my right to revise my personal information or to withdraw consent at any time in accordance with the clinic's privacy policy.

Name of client:

(and others in attendance)

Patient Signature:

Contact Phone Number:

Client's Practitioner Name:

Signature of person assessing consent outcomes:

Date:

(Completed form to be kept by Practitioner in clinic records)