

Appendix 15 – Paper consent form

Health information: Covid-19 consent form

Name
(please print)

Date

Covid-19 screening information

- | | | | |
|---|---|----------------------------|----------------------------|
| 1 | Have you had a fever in the last 7 days?
(feeling hot to touch on your chest and back) | Y
<input type="radio"/> | N
<input type="radio"/> |
| 2 | Do you now, or have you recently had, a persistent dry cough?
(coughing a lot for more than an hour, 3 or more coughing episodes in 24 hours or worsening of a pre-existing cough) | Y
<input type="radio"/> | N
<input type="radio"/> |
| 3 | Have you lost sensations of taste and smell? | Y
<input type="radio"/> | N
<input type="radio"/> |
| 4 | Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms? | Y
<input type="radio"/> | N
<input type="radio"/> |
| 5 | Have you been told to stay home, self-isolate or self-quarantine? | Y
<input type="radio"/> | N
<input type="radio"/> |
| 6 | Do you or anyone that you live with fall into the 'clinically vulnerable' or 'clinically extremely vulnerable' categories as defined below? | Y
<input type="radio"/> | N
<input type="radio"/> |

Consent for treatment

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 give my consent to receive treatment from this practitioner.

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