TCM Practice
balancing the body

Health information: **Covid-19 consent form**

Name
(please print)

Today's date

Date of birth

Covid-19 screening information

	Y	N
Have you had a fever in the last 7 days? **(feeling hot to touch on your chest and back)**		
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)**		
Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms?		
Have you been told to stay home, self-isolate or self-quarantine?		
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)**		

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 give my consent to receive treatment from this practitioner.**

I confirm that I am over 18 years old.

I am the **Patient** ☐ **Parent/Carer** ☐ **Practitioner**

Name		Ilze Black
Signed		
Date		