Patient Questionnaire re COVID-19

The information you provide remains strictly confidential and part of your clinical records

Patient's Name: _____

Patient's Address: _____

_____

_____ Postcode: _____

Email: _____@_____ Date of Birth: ____/____/____

Telephone: _____ Mobile: _____

Questions

1. Have you got a cough, high temperature or shortness of breath now, or have had any time in the last 7 days? Yes / No

2. Have you lost your sense of taste or smell? Yes / No

3. Does anybody in your household have a cough, high temperature, shortness of breath, or have a confirmed, positive test or COVID-19 diagnosis? Yes / No

   If so, who? _____

I confirm that I have been advised by _____ Chiropodist / Podiatrist.

All Health and Safety protocols have been put in place to provide me with a safe environment in the clinical / domiciliary setting for a treatment. In accordance with Public Health England, regarding infection control and prevention for all health circumstances, including COVID-19.

I confirm that in the last 7 days I have had NO signs or symptoms of COVID-19, such as a new cough, high temperature, fever, or loss of, or change in sense of smell and taste, nor have I come into contact with anyone known to have symptoms to the best of my knowledge.

I understand that every precaution and procedure has been taken by _____ (Chiropodist / Podiatrist).

To limit the spread of any infection, infection control and prevention measures have been extended, to include the wearing of full PPE and screening, as necessary for my personal safety.

However, the risk of contracting COVID-19 can never be zero, and I therefore, have carefully considered the benefit of receiving a treatment against the risk of becoming infected with COVID-19, by giving my consent.

Patient or person completing the form

Name: _____

Signature: _____ Date: _____/_____/_____

If any answers are "YES" to the questions above, please do NOT proceed with any treatment, and as necessary, refer to the Clinical Lead or Manager.

To be completed by a Parent / Guardian / Other member of family / Other person in loco parentis / Carer

On behalf of the person named herein as the Patient, who is known to me, I hereby confirm that to the best of my knowledge, the above statement is true.

Signature: _____ Date: _____/_____/_____

Legal capacity / Authority to sign: _____

Name: _____

Address: _____

_____ Postcode: _____

Tel (Home): _____ Mobile: _____

Tel (Work): _____ Email: _____@_____