**CONSULTATION & CONSENT DOCUMENT**

**SPECIFIC COVID-19 SCREENING**

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| --- | --- | --- | --- |
| **FULL NAME** |  | | |
| **FULL ADDRESS** |  | | |
| **POST CODE** |  | | |
| **EMAIL ADDRESS** |  | | |
| **MOBILE NUMBER** |  | | |
| **TESTING** | | | |
| 1, Have you had a Covid-19 test? | | YES | NO |
| 2, If positive, did you self-isolate? | | YES | NO |
| 2 (a) If positive, have you been screened for blood-clots? | | YES | NO |
| 2 (b) If yes for blood-clots, has your GP agreed to this massage? | | YES | NO |
| 3, If tested, what was the date you tested negative? | |  | |
| 4, Do you still have symptoms? | | YES | NO |
| 5, Are you registered on the NHS Track & Trace app? | | YES | NO |
| **SYMPTOMS -** Are you experiencing any of the following? | | | |
| 6, Severe breathing difficulties or chest pain? | | YES | NO |
| 7, Difficulty in waking or confusion? | | YES | NO |
| **If yes to any of the above call 999** | | | |
| 8, Fever? (Temperature above 37.8 degrees Celsius) | | YES | NO |
| 9, Previous symptoms getting worse? e.g. cough | | YES | NO |
| 10, Sore throat or runny nose? | | YES | NO |
| **If any of the above, the advice is to self-isolate for 7 days** | | | |
| 11, Chills or headache? | | YES | NO |
| 12, Painful swallowing? | | YES | NO |
| 13, Muscle & joint ache? | | YES | NO |
| 14, Fatigue or exhaustion? | | YES | NO |
| 15, Loss of taste or smell? | | YES | NO |
| **If any of the above, the advice is to self-isolate for 7 days.**  **Then taking a test will be necessary. Call 119** | | | |
| 16, Shortness of breath or difficulty lying down due to chest issues? | | YES | NO |
| **If any of the above, contact your GP or call 111** | | | |
| 17, Have you been in contact with anyone with Covid-19 symptoms? | | YES | NO |
| 18, Have you had or are you now experiencing Covid-10 symptoms? | | YES | NO |
| 19, Are you taking your temperature regularly?  20, If so, what is the latest reading?.................................................... | | YES | NO |
| 21, Have you recently been hospitalised? | | YES | NO |
| 22, If so, why? – please describe: | | | |
| **Do you have any of the following health issues** | | | |
| 23, High blood pressure or other heart condition? | | YES | NO |
| 24, Diabetes Type 1 or 2 – if so, which? | | YES | NO |
| 25, Cancer? | | YES | NO |
| 26, Lung condition? | | YES | NO |
| 27, Any other conditions – please list: | | | |
| **Are you?** | | | |
| 28, An NHS front line worker? | | YES | NO |
| 29, A carer – home or care home? | | YES | NO |
| 30, Shielding a vulnerable adult? | | YES | NO |
| 31, Pregnant – how many weeks? | | YES | NO |
| 32, Aged Over 70 –   * will you have a companion with you? | | YES | NO |
| 33, Allergic to latex gloves? | | YES | NO |
| 34, Allergic to cleaning products?  35, If yes please specify | | YES | NO |
| **SIGNED**  I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.  If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Track & Trace I will inform you.  I consent for you to inform NHS Track & Trace if so required.  **Full name**: ………………………………………… **Signed** ………………………………………..……  **Date**: ……………………………… | | | |



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| **Follow Up Appointments**  **Any changes to the declaration for: (Name)**  **Originally signed on: (Date)** |

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| **Date** | **Any Changes? If so, please detail……. Or NONE** | **Signature** |
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