

## CONSULTATION & CONSENT DOCUMENT SPECIFIC COVID-19 SCREENING

FULL NAME		
FULL ADDRESS		
POST CODE		
EMAIL ADDRESS		
MOBILE NUMBER		
<b>TESTING</b>		
1, Have you had a Covid-19 test?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2, If YES, what date was your test?		
2 (a) If positive, did you self isolate?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2 (b) If positive, have you since tested negative?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3, Date you tested negative for Covid-19?		
4, Do you currently have any symptoms of Covid-19?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5, Are you registered on the NHS Track & Trace app?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>SYMPTOMS</b> - Are you experiencing any of the following?		
6, Severe breathing difficulties or chest pain?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7, Difficulty in waking or confusion?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>If yes to any of the above call 999</b>		
8, Fever? (Temperature above 37.8 degrees Celsius)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
9, Previous symptoms getting worse? e.g. cough	YES <input type="checkbox"/>	NO <input type="checkbox"/>
10, Sore throat or runny nose?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>If any of the above, the advice is to self-isolate for 7 days</b>		
11, Chills or headache?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
12, Painful swallowing?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
13, Muscle & joint ache?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
14, Fatigue or exhaustion?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
15, Loss of taste or smell?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>If any of the above, the advice is to self-isolate for 7 days.</b>		
<b>Then taking a test will be necessary. Call 119</b>		
16, Shortness of breath or difficulty lying down due to chest issues?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<b>If any of the above, contact your GP or call 111</b>		

17, Have you been in contact with anyone with Covid-19 symptoms?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
18, Have you had or are you now experiencing Covid-10 symptoms?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
19, Are you taking your temperature regularly?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
20, If so, what is the latest reading?.....		
21, Have you recently been hospitalised?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
22, If so, why? – please describe:		
<b>Do you have any of the following health issues</b>		
23, High blood pressure or other heart condition?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
24, Diabetes Type 1 or 2 – if so, which?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
25, Cancer?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
26, Lung condition?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
27, Any other conditions – please list:		
<b>Are you?</b>		
28, An NHS front line worker?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
29, A carer – home or care home?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
30, Shielding a vulnerable adult?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
31, Pregnant – how many weeks?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
32, Aged Over 70 – - will you have a companion with you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
33, Allergic to latex gloves?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
34, Allergic to cleaning products?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
35, If yes please specify		
<b>SIGNED</b>		
<p>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.</p> <p>If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Track &amp; Trace I will inform you.</p> <p>I consent for you to inform NHS Track &amp; Trace if so required.</p> <p><b>Full name:</b> ..... <b>Signed</b> .....</p> <p><b>Date:</b> .....</p>		