

## SMITHBROOK CLINIC CONSENT FORM

PATIENT NAME.....

DATE OF BIRTH.....

Have you suffered from or been diagnosed with  
COVID-19?.....YES or No

Have you had any of the following COVID-19 symptoms in the last 7 days?

- A high temperature.....Yes or No
- A new continuous cough.....Yes or No
- A loss of, or change to your sense of smell or  
taste?.....Yes or No
- If Yes to any of the above, have you been tested for COVID-19 and  
had a negative result?.....Yes or No
  
- Have you been in contact with anyone with COVID-19  
symptoms in the last 14 days?.....Yes or No
  
- Are you in the category of vulnerable shielding patients?.....Yes  
or No
  
- I confirm that I will inform my therapist if I, anyone else I live with, or anyone I  
have knowingly been in contact with, develops symptoms and/or is diagnosed  
with COVID-19, whilst I am undergoing treatment?.....Yes or No
  
- I confirm that I have received via email and have read the COVID-19 Patient  
Information document explaining the precautions taken by Smithbrook Clinic to  
avoid contamination?.....Yes or No

I understand that under current Covid-19 guidelines, my practitioner will triage me by telephone or video before I can attend for a face to face consultation. If my treatment needs cannot subsequently be dealt with remotely, then having read the Smithbrook Clinic patient information sheet, I consent to face to face treatment with David Reynolds.

**Patient Signature**..... **Date**.....

**Parent/Guardian if patient is under 18**