SOUTHVIEW 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 Southview 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 Southview Clinic patient information sheet, I consent to face to face treatment with Alex or David Reynolds.

Patient Signature..... **Date**.....
Parent/Guardian if patient is under 18