

# MOVE & IMPROVE

## COVID-19 Screening questionnaire

### Personal Details

Name: \_\_\_\_\_

### About Me:

I confirm that I have not had any of the following symptoms in the last 14 days: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose or sore throat.

Yes  No

I confirm that I am not in the clinically extremely vulnerable category and therefore advised to shield at home by the government.

Yes  No

I confirm that to the best of my knowledge, I have not been in close contact with anyone with confirmed COVID-19 in the last 14 days.

Yes  No

I understand that coronavirus may not cause symptoms in some people and is currently causing a pandemic which means healthcare services are required to operate differently

Yes  No

I confirm I have been made aware of physiotherapy guidelines that require a telephone/video triage appointment to be conducted before I can attend in person.

Yes  No

### About my visit

I confirm I am aware of the clinic's requirement for social distancing in the clinic.

Yes  No

I confirm I am aware of the clinic's requirement for hand decontamination as I enter the clinic:

Yes  No

I confirm I am aware if the clinic requires me to wear a face-covering whilst inside the clinic:

Yes  No

I confirm I have been told about the cleaning of the clinic room before/after my attendance:

Yes  No

I confirm I am aware of the clinic's requirement for contactless payment

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Yes  No

I understand that my physiotherapist is required to wear PPE as set by Public Health authorities during my appointment and this is not optional for them.

Yes  No

## About my clinician

They have confirmed they have not had any of the following symptoms in the last 14 days: fever, shortness of breath, loss of sense of taste or smell, dry cough, runny nose or sore throat:

Yes  No

They have confirmed that to the best of their knowledge, they have not been in close contact with anyone with confirmed COVID-19 in the last 14 days.

Yes  No

They have discussed with me the reasons why my clinical need for healthcare cannot be met by a telephone/video consultation.

Yes  No

I have had the opportunity to ask all the questions I wish to, and all of my questions have been answered to my satisfaction. Use space below to record details:

I agree to attend a face to face appointment during the COVID-19 pandemic.

Yes  No

Patient signature \_\_\_\_\_

OR [delete as applicable] signature of person with parental responsibility/person legally entitled to sign on behalf of a person who lacks capacity

Signature \_\_\_\_\_

Signed Therapist \_\_\_\_\_

Date: \_\_\_\_\_