

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