***AGREEMENT FOR A FACE TO FACE APPOINTMENT***

**Personal Details**

Name: Date of birth:

Address:

Telephone:

Email address:

**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.( If in the moderately vulnerable discuss with therapist)

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 ⬜ or had a Covid 19 test ( see below)

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 ⬜

Covid 19 test. Have I received a Covid 19 test? (Yes/No)……………….

If yes. Date …………………….. Outcome………………………………………………

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 in 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 ⬜ (exemptions may apply. discuss with therapist)

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

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 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 ⬜

**Signed Patient** ……………………………………………………………………….. Date…………………………….

OR [delete as applicable]

**Signature of person with parental responsibility / person legally entitled to sign on behalf of a person who lacks capacity**

………………………………………………………………………………………………

**Signed Therapist**………………………………………………………………… Date ………………………………..

**1. PLEASE SEND THIS DOCUMENT BACK TO JACKIE.** [**ZASJACKIE@GMAIL.COM**](mailto:ZASJACKIE@GMAIL.COM) **AS AN ATTACHMENT OR**

**2. Print and bring to your appointment.**

**NB without the consent form the Face to face appointment cannot occur.**

**3. Call me and I will go through it verbally and you will need to sign on your arrival at the clinic.**