COVID-19 Patient Screening form

To help prevent the spread of COVID-19 in the every patient must answer the following questions and an appointment will be given or not on review of this form. N.B. Every question **must** be answered.

Patient Name:	Date
Appointment Date:	
Question	Yes / No
In the last 14 days have you had any of the following symptoms cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms	
Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days?	
Are you a close contact of a person who is a confirmed or suspected case of COVID-19 in the past 14 days (i.e. less than 2 metres for more than 15 minutes accumulative in 1 day)?	
Have you been advised by a doctor to self-isolate at this time?	
Have you been advised by a doctor to cocoon at this time?	
Please provide details below of any other circumstances relating to COVID-19, not included in the above, which may need to be considered before you present for treatment. Further information on people at higher risk from Coronavirus can be accessed here.	

*if you are unsure whether or not you are in an at-risk category, please check the information at the link in Question 6.

** If your situation changes after you complete this form and before your appointment please notify us immediately.

If you have your own mask please bring it with you to your appointment

Print Name:…….Signature……Date: ……

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