

**Deborah Donohoe**

**Total Health 4U**

**Therapeutic Massage Therapist**

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**CONSULTATION & CONSENT DOCUMENT – SPECIFIC COVID-19 SCREENING**

<b>FULL NAME</b>			
<b>FULL ADDRESS</b>			
<b>POST CODE</b>			
<b>EMAIL ADDRESS</b>			
<b>MOBILE NUMBER</b>			
<b>TESTING</b>			
Have you had a Covid-19 test	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Did you self-isolate	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
What was the date you tested negative			
Do you still have symptoms	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Are you registered on the NHS Track & Trace app	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
<b>SYMPTOMS - Are you experiencing any of the following?</b>			
Severe breathing difficulties or chest pain	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Difficulty in waking or confusion	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
<b>If yes to any of the above call 999</b>			
Fever	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Previous symptoms getting worse: cough	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Sore throat or runny nose	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
<b>If any of the above, the advice is to self-isolate for 7 days</b>			
Chills or headache	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Painful swallowing	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Muscle & joint ache	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Fatigue or exhaustion	YES	<input type="checkbox"/>	NO <input type="checkbox"/>
Loss of taste or smell	YES	<input type="checkbox"/>	NO <input type="checkbox"/>

**If any of the above, the advice is to self-isolate for 7 days. Then taking a test will be necessary. Call 119**

Shortness of breath or difficulty lying down due to chest issues	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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**If any of the above, contact your GP or call 111**

Have you been in contact with anyone with Covid-19 symptoms?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Have you had or are you now experiencing Covid-10 symptoms?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Are you taking your temperature regularly? If so, what is the latest?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Have you recently been hospitalised?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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If so, why – please describe:

**Do you have any of the following health issues**

High blood pressure or other heart condition	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Diabetes Type 1 or 2 – if so, which?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Cancer	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Lung condition	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Any other conditions – please list:

**Are you?**

An NHS front line worker	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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A carer – home or care home	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Shielding a vulnerable adult	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Pregnant – how many weeks?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Over 70 – will you have a companion with you?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Allergic to latex gloves	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Allergic to cleaning products – if yes please specify	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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**SIGNED**

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.

If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Track & Trace I will inform you.

I consent for you to inform NHS Track & Trace if so required.

Full name: .....

Date: .....

## THERAPIST DECLARATION & CONSENT FORM – COPY FOR CLIENT

<b>FULL NAME</b>	
<b>FULL ADDRESS</b>	
<b>POST CODE</b>	
<b>EMAIL ADDRESS</b>	
<b>MOBILE NUMBER</b>	
I do not have Covid-19 to my knowledge	
I have/ have not been tested for Covid-19	
The test was negative	
I take my temperature every day	
I have not been in contact with anyone with Covid-19, to my knowledge	
I am connected to the NHS Track & Trace app	
If either I, or a client, tests positive for Covid-19 I will inform you immediately	
<b>SIGNED</b>	
I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true.	
If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.	
Full name: .....	
Date: .....	