**COVID-19 Screening**

Client Full Name ………………………………………………………………………………DOB…………………………………………………………

Contact Phone No…………………………………………………Email…………………………………………………………………………………..

**COVID-19 Screening when making the appointment**

Q1. Have you ever been tested for COVID-19? Yes No

Q2. Have you ever tested positive for COVID-19? Yes No

If yes, were you hospitalised? Yes No

Q3. Are you currently taking medication for COVID-19 symptoms? Yes No

**If you have answered ‘yes’ to either Q2 or Q3 treatment can only proceed once GP approval has been granted.**

Q4. Have you or any of your household been contacted by the ‘Test & Trace’ team and been advised to self-isolate? Yes No

**If ‘yes’, treatment can only take place once the period of self-isolation has been completed**

Q5. Do you or any members of your household currently have any symptoms of COVID-19?

**High temperature** – this means you feel hot to touch on your chest or back (you do not need to measure your temperature) Yes No

**New, continuous cough** – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual) Yes No

**Loss or change to your sense of smell or taste** – this means you’ve noticed you cannot smell or taste anything, or things smell or taste different to usual Yes No

**Are you considered to be in the High-Risk group that was shielding?** Yes No

**If ‘yes’ treatment can proceed once GP approval has been granted.**

**Consent Declaration for Face to Face Appointments during COVID-19**

The information I have given in this form is honest, accurate and correct to the best of my knowledge. I have had the opportunity to ask all the questions about its content, and all of my questions have been answered to my satisfaction. I appreciate that although all reasonable steps to reduce risk of infections have been taken, including screening potential Covid-19 cases and undertaking increased hygiene and distancing protocols there may still be a risk of infection from face to face treatment. I knowingly and willing consent for Face to Face appointment to take place.

Client Signature: …………………………………………………. Date: …………………………………………

**Data Protection Policy**

"Pulse Therapy fully complies with the most up to date Data Protection Policy and has a transparent approach to Data Processing which empowers individuals to know about the collection and use of their personal data. We collect data for ensuring we have the right information for assessing your suitability to treatment, for completing the appropriate treatment, for contacting you regarding appointment follow-ups and for a referral to GP or other healthcare practitioners if deemed necessary. Your data may be viewed by clinic staff to ensure continuity of care is given and for standards clinic running purposes. In addition, the data may also be shared with NHS Test and Trace if required to minimise the spread of Covid-19. We collect only data that is relevant to those purposes, and we keep it for 7 years. All information held will be treated as strictly confidential and will only be released to any other external party with the consent of the client."

*I have read Pulse Therapy’s Data Protection Policy and consent to Pulse Therapy processing records as outlined above and understand that I can withdraw my consent on the processing of data at any time.*

Client Signature: ………………………………………………. Date: …………………………………………….

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**THERAPIST** to review screening information and client consent before each subsequent treatment proceeds:

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