British Acupuncture Council Member

professional standards authority accredited register

Health information: Covid-19 consent form

Name **(please print)**

Today's date

Date of birth **(if under 18 years)**

Covid-19 screening information

		Y	N
1	Have you had a fever in the last 7 days? **(feeling hot to touch on your chest and back)**	☐	☐
2	Do you now, or have you recently had, a persistent dry cough? **(coughing a lot for more than an hour or 3 or more coughing episodes in 24 hours or a worsening of a pre-existing cough)**	☐	☐
3	Have you been in contact with anyone in the last 14 days who has been diagnosed with Covid-19 or has coronavirus-type symptoms?	☐	☐
4	Have you been told to stay home, self-isolate or self-quarantine?	☐	☐
5	Do you have any other symptoms that may mean you have a Covid-19 infection? **(loss of taste and smell, unusual fatigue or shortness of breath)**	☐	☐

People at high risk (clinically extremely vulnerable)*

	Y	N
Please select **Y** if **any** of the following apply to you:	☐	☐

- had an organ transplant
- having chemotherapy or antibody treatment for cancer, including immunotherapy
- having an intense course of radiotherapy (radical radiotherapy) for lung cancer
- having targeted cancer treatments that can affect the immune system (such as protein kinase inhibitors or PARP inhibitors)
- have blood or bone marrow cancer (such as leukaemia, lymphoma or myeloma)
- had a bone marrow or stem cell transplant in the past 6 months, or still taking immunosuppressant medicine
- told by a doctor that you have a severe lung condition (such as cystic fibrosis, severe asthma or severe COPD)
- have a condition that means you have a very high risk of getting infections (such as SCID or sickle cell)
- taking medicine that makes you much more likely to get infections (such as high doses of steroids)
- pregnant and have a serious heart condition

*If you select **Yes** after reading this list, the practitioner should explain that you are classed as **clinically extremely vulnerable** and the government advise that you exercise '**shielding**'. Current government advice says that for your protection and until 30 June 2020, you should stay at home at all times and avoid face-to-face contact with anyone outside your own household.

People at moderate risk (clinically vulnerable)

Please select **Y** if **any** of the following apply to you:

Y	N
◯	◯

- 70 or older
- pregnant
- have a lung condition that is not severe (such as asthma, COPD, emphysema or bronchitis)
- have heart disease (such as heart failure)
- have diabetes
- have chronic kidney disease
- have liver disease (such as hepatitis)
- have a condition affecting the brain or nerves (such as Parkinson's disease, motor neurone disease, multiple sclerosis or cerebral palsy)
- have a condition that means you have a high risk of getting infections
- taking medicine that can affect the immune system (such as low doses of steroids)
- very obese (BMI of 40 or above)

If you select **Yes** after reading this list, you are at **moderate** risk from coronavirus and it is very important you follow the advice on social distancing.

Consent for treatment

I declare that the information I have provided is correct to the best of my knowledge and I understand that, because my treatment may involve touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including Covid-19.

I consent to the practitioner retaining the details provided on this form for a period of 7 years from today. I further understand that if I am under 18 years of age, these records will be kept until I reach the age of 25 (7 years after reaching 18).

I give my consent to receive treatment from this practitioner.

I am the	**Patient** ◯ ***Parent/Guardian/Carer** ◯	**Practitioner**
Name		
Signed		
Date		

***If you are signing on behalf of the patient, or if the patient is a minor, please state your relationship with the patient below:**

I am the patient's