

## COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organisation (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. I have been provided with information regarding benefits and risks of receiving treatment at this time from AMANDA MARSH PHYSIOTHERAPY to assist me in making an informed choice. I understand that although all necessary precautions have been taken, it is impossible to determine who has, and who does not have the virus, given the current limits in virus testing.

I understand the clinic will be taking precautionary measures in that:

- I will come up to the clinic no earlier than 5 minutes before my appointment time
- I will have my temperature taken by forehead non-contact digital thermometer
- I will be wearing a face covering/mask whilst in the enclosed clinic space
- My practitioner will be wearing face mask, gloves, and apron for my treatment
- I will use hand sanitiser on entrancing and exiting the clinic
- Payment will be online or by telephone

***To proceed with receiving care, I confirm and understand the following:***

- I understand my treatment may create circumstances such as the discharge of respiratory droplets or person to person contact, in which COVID-19 can be transmitted.
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date or continue remotely. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare clinic.
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

\*Fever

\*Persistent new Dry Cough

\*Sore Throat

\*Shortness of Breath

\*Runny Nose

\*Loss of taste or smell

- I have not travelled outside of the UK in the last 14 days and I am not meant to be in quarantine now
- I may be contacted as part of track and trace in the event of someone else having tested positive to Covid-19

I acknowledge that the practice may reschedule the appointment for elective care if I am exhibiting symptoms of COVID-19, fail the temperature check, have recently travelled abroad or been subject to a known exposure event.

PRINT NAME \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_