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COVID19 Health Screening Questionnaire for Face to Face Consultation

Our governing bodies, the Chartered Society of Physiotherapy (CSP) and the Health Professions Council require us to assess the risks for all patients for whom we are considering face to face consultations.

Before we can consider a face to face consultation please read, complete and sign the declaration in the following questionnaire.
You must complete all questions. No Face to Face consultation will be booked until this document has been received

Have you had a test for COVID-19? **Yes/No**

If yes, when? **_____(Date)**

If yes what was the result? **Positive/Negative**

In the last 14 days have you had a temperature or new cough? **Yes/No**

In the last 14 days, have you had any other symptoms that could have been attributed to a mild case of Covid-19? (e.g headache, cold /flu type symptoms, loss of smell/taste, unusual tiredness, diarrhoea, widespread joint and muscle aches and pains)

Yes/No

In the last 14 days, have you been exposed to anyone with confirmed COVID-19? **Yes/No**

What is your current work status? **Retired/Working**

If working give details
- **working from home / working with little outside interaction?** ◯
- **Working in a low traffic area/outside/ small office with social distancing practised?** ◯
- **Working in contact with several other people e.g. supermarket?** ◯
- **Working with COVID-19 positive or suspected cases?** ◯
- **Working other (Give details)** ◯

(Please tick which best describes your situation)

Have you or anyone in your household been advised to shield? **Yes/No**

Do you, or any of your household, fall into any of the following categories?

Age 70 or over **Yes/No**

Do you have an ongoing illness or condition which may make you more vulnerable to becoming unwell such as diabetes, respiratory problems (Asthma, COPD, Chest infection) heart problems?

Yes/No

Does anyone in your house hold suffer with any of the above?

If yes give details_____

Do you have regular close contact with a vulnerable individual such as an elderly person, or an individual with ongoing illness such as those listed above? Yes/No

If yes give details_____

Special Questions:
Do you, or any members of your household fall into the following categories? (Please tick)

Respiratory problems e.g severe or regular asthma attacks, chronic obstructive pulmonary disease (COPD), cystic fibrosis or are prone to chest infections, heart problems, diabetes ◯
Auto immune illness (e.g rheumatoid arthritis or with rare diseases that significantly increase the risk of infections) ◯
Solid organ transplant recipients. ◯
People with specific cancers, those undergoing active chemotherapy or radical radiotherapy? ◯
Cancers of the blood or bone marrow e.g leukaemia, lymphoma or myeloma who are at any stage of treatment, immunotherapy or other continuing antibody treatments or targeted cancer treatments ◯
People on immunosuppression therapies sufficient to significantly increase their risk of infection. ◯

None of these ◯

Are you or any members of your household pregnant? Yes/No

Please give details of any other relevant medical information.

_____

_____

_____

NB: If the answer to any of these questions is yes, we must consider extremely carefully if Face to Face Physiotherapy Consultation would be appropriate.

For the safety of all concerned:

I solemnly and sincerely declare that the information I have provided is true and, to the best of my knowledge, correct. If any person should suffer as a result of the information being found to be untrue or false I am aware that I could be prosecuted for making a false declaration.

I confirm that I will inform the physiotherapist of ANY CHANGE in status to my current health as detailed above before leaving home for any face to face consultation ◯

In the event that I develop any symptoms associated with COVID19 or indeed test positive, within 14 days of the consultation, I will inform the Physiotherapist immediately in order that any contacts can be traced and informed ◯

Name……
(Patient Name)

Name…… Date……

(Patient Signature)

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NB: Your current state of health will be reviewed before every future follow-up consultation.

Review Appointment:

Date: ……..

I confirm that there have been no changes to my state of health since my last consultation, and that I have not knowingly come into contact with any persons who have Covid 19 symptoms

Signed ……..……..

Date: ……..

I confirm that there have been no changes to my state of health since my last consultation, and that I have not knowingly come into contact with any persons who have Covid 19 symptoms

Signed ……..

Date: ……..

I confirm that there have been no changes to my state of health since my last consultation, and that I have not knowingly come into contact with any persons who have Covid 19 symptoms

Signed ……..……..

QUESTIONAIRE REVIEW DATE: JULY 2020, or sooner in line with Government/PHE/Professional Regulatory Bodies advice.