**Patient Information and Consent Form**

**Risk of Coronavirus (COVID-19) Transmission at [Insert Practice Name]**

**Please read this form, discuss with your chiropractor if necessary and sign where indicated.**

**\*This Form is in addition to consent form for chiropractic examination and treatment\***

The Government published a Statutory Instrument on 26th March 2020, ***no. 350 ‘The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020’***confirming that it is lawful for a chiropractic practice to remain open. It further defines those people who are classed as ‘vulnerable’.

In accordance with up-to-date Government and Public Health England guidance [Insert Practice Name] has taken precautions to protect our patients and team members.  These include rigorous sanitization procedures.  **We also request that any symptomatic patients follow NHS guidance on self-isolation and refrain from visiting the practice at this time.**  Despite this, there is a risk of transmission of the Coronavirus (COVID-19) and it is important that you are aware of the risk.

**PRECAUTIONS THAT [INSERT PRACTICE NAME] HAS IN PLACE:**

* **All patients contacting us for an appointment are triaged by a member of our team over the telephone to establish their status (asymptomatic / symptomatic / self-isolating / living with someone symptomatic or self-isolating / have been in contact with anyone symptomatic).**
* **Only people in the asymptomatic category can attend the practice.**
* **A second triage is conducted at the practice by a team member.**
* **A strict cleaning, sanitation and infection control protocol is adhered to.**
* **All team members at [Insert Practice Name] follow government social distancing guidance where possible.**
* **Practice layout has been adapted to maintain social distancing between patients and all team members where possible.**

# **ELIGIBILITY FOR CARE**

In addition to those with COVID-19 symptoms, self-isolating, living with someone with symptoms/ self-isolating, or have been in contact with anyone with or suspected to have COVID-19, we are currently not accepting patients from the ‘vulnerable’ and ‘extremely vulnerable’ at risk groups defined below:

1. Pregnant
2. Over 70
3. Have a long-term health condition/ Underlying Medical Conditions as listed below:
* Chronic respiratory diseases, such as asthma, COPD, emphysema or bronchitis.
* Chronic heart disease, such as heart failure.
* Chronic kidney disease.
* Chronic liver disease, such as hepatitis.
* Chronic neurological conditions, such as Parkinson’s disease, motor neurone disease, multiple sclerosis, a learning disability or cerebral palsy.
* Diabetes.
* Problems with the spleen, such as sickle cell disease or removal of the spleen.
* A weakened immune system due to conditions such as HIV and AIDS, or medicines such as steroid tablets or chemotherapy.
* Being seriously overweight, (body mass index of 40 or above).

**CONSENT TO RECEIVE CARE AT [INSERT PRACTICE NAME]**

* I have answered all questions (triage) relating to my potential exposure to Coronavirus (COVID-19) truthfully; specifically I am not currently symptomatic, nor am I self-isolating, nor am I living with anyone who is symptomatic or self-isolating, nor have I been in contact with anyone who has or is suspected of having COVID-19.
* I understand that there is a potential risk of transmission of Coronavirus (COVID-19) as a result of attending the practice and/or receiving treatment.
* I have had the opportunity to ask all the questions I wish to, and all my questions have been answered to my satisfaction.
* I have read, agreed to and understood the statements above relating to Coronavirus (COVID-19) risk and consent to receive care at [Insert Practice Name].
* I understand and agree that I will need to give separate consent regarding my chiropractic care.

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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