**Covid-19 Triage Screening Questionnaire - Wellness Centre Dumfries**

**Please delete or score through Yes/No to each of these**

**1 Have you had a high-temperature fever in the last 7 days? Feeling hot to touch on chest, back or legs Yes/No**

**2 Do you now, or have you recently had, a persistent dry cough or worsening of a pre-existing cough? Yes/No**

**3 Have you been in contact with anyone in the last 10 days who has**

**been diagnosed with Covid-19 or has coronavirus-type symptoms? Yes/No**

**4 Have you been told to stay home, self-isolate or self-quarantine? Yes/No**

**5 Do you have loss of taste and smell, unusual fatigue or shortness of breath? Yes/No**

**By signing I agree that my personal information can be passed on to the NHS track and trace system should the clinic be linked to a Covid 19 outbreak.**

**Client Consent for treatment**

**I understand that, because my treatment may involve close contact with my practitioner, there may be an elevated risk of disease transmission including Covid 19**

**I give my consent to receive treatment from this practitioner i.e.. Lynda Sharp**

**Yes/No Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **For Practitioner to fill in****I have explained COVID hygiene and safety protocols to this client and have asked the triage questions. I am satisfied that it is safe to treat this client at this clinic****Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |