Patient Screen & Covid Screen – return visit

Please complete this form as fully as possible and provide all contact details.

First name	
Surname	
Date of birth	
Contact number for use on day of treatment	
Email address	
Date	
Emergency contact name and telephone number	

Do you have any active Covid symptoms-cough, sore throat, high temperature, altered sense of taste or smell, breathing issues, flu-like symptoms or rashes?	
Have you been advised to self- isolate, shield or remain at home?	
Have you been tested positive for Covid or are you awaiting test results?	
Have you been in contact with anyone within the last 14 days who either has Covid symptoms, has been diagnosed with Covid, or may have Covid	
Are you a front line worker who has been exposed to Covid-19 patients within the last 14 days?	
Have you left the UK within the last 14 days?	
Have you been on an aircraft within the last 14 days?	
Have you travelled within any of the government lockdown areas/risk areas within the last 14 days?	
Do you live with anyone classed as high risk or who has been shielded?	
Have you had your 1st Covid Vaccine? Date of Vaccine	
Have you had your 2nd Covid Vaccine Date of Vaccine	

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.

Signed……Dated……