

**COVID-19 SCREENING AND CONSENT**

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| --- | --- |
| **FULL NAME** |  |
| **DATE OF BIRTH** |  |
| **EMAIL ADDRESS** |  |
| **MOBILE NUMBER** |  |
|  |
| **TESTING** |
| Have you had a Covid-19 test? If yes, when? Antigen or antibody test?**Antigen** – tests for Covid-19 on day of testing. **Antibody** – possible immunity | YES Date: | NO  |
| If it was a positive result, has the isolation period expired? | YES  | NO  |
| Do you still have symptoms? | YES  | NO  |
| Are you registered with the NHS Test & Trace app | YES  | NO  |
| **SYMPTOMS -** Are you experiencing any of the following? |
| Severe breathing difficulties or chest pain | YES  | NO  |
| Difficulty in waking or confusion | YES  | NO  |
| **If yes to any of the above call 999** |
| Fever | YES  | NO  |
| Onset, or worsening of a cough | YES  | NO  |
| Sore throat or runny nose | YES  | NO  |
| Chills or headache | YES  | NO  |
| Pain swallowing | YES  | NO  |
| Muscle & joint ache | YES  | NO  |
| Fatigue or exhaustion | YES  | NO  |
| Loss of taste or smell | YES  | NO  |
| **If any of the above, the advice is to self-isolate for 7 days. A Covid-19 test may be necessary, call 119** |
| Shortness of breath or difficulty lying down due to chest issues | YES  | NO  |
| **If any of the above, call 111** |
| Have you been in contact with anyone with Covid-19 symptoms? | YES  | NO  |
| Have you recently been hospitalised | YES  | NO  |
| If so, why: |
| **Do you have any of the following health issues?** |
| High blood pressure or other heart condition | YES  | NO  |
| Diabetes Type 1 or 2 – if so, which? | YES  | NO  |
| Cancer | YES  | NO  |
| Lung condition | YES  | NO  |
| Any other conditions – please list: |
| **If you have had Covid-19:** |
| Are you experiencing post Covid-19 circulatory complications (deep vein thrombosis, micro-embolisms, stroke symptoms or pulmonary embolism) | YES  | NO  |
| **Are you?** |
| An NHS front line worker | YES  | NO  |
| A carer – home or care home | YES  | NO  |
| Shielding a vulnerable adult | YES  | NO  |
| Pregnant – how many weeks? | YES  | NO  |
| Aged over 70 | YES  | NO  |
| Allergic to latex gloves or specific cleaning products | YES  | NO  |
| **SIGNED**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.If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Test & Trace I will inform you.Full name…………………………………………Date……………………………………………… |

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