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

**Please tick yes or no to each of these**

**1 Have you had a high-temperature fever in the last 7 days?**

**(feeling hot to touch on your chest and back and 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 14 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**

**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.**

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

**I am the Patient \*Parent/Guardian/Carer Practitioner**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*If you are signing on behalf of the patient, or if the patient is a minor, please state your**

**relationship with the patient below:**

**I am the patient’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |