COVID-19 RISK ASSESSMENT QUESTIONNAIRE

Patient's Name: ……. Date: …….

Patient's DOB: ……...

Has the patient ever been tested for COVID-19?	**Yes**	**If yes result +ve /-ve Date :**	**No**
Does the patient or anyone else living in the house have symptoms of COVID-19?	**Yes** **(If yes the patient will be offered a remote session only).**	**If yes are they self isolating?** **Yes / No**	**No**
Has the patient been offered a remote session?	**Yes**	**No**	
Has a remote session been completed?	**Yes**	**No**	**If No explain why?**
Does the patient require face to face treatment?	**Yes**	**Justification for face to face consultation:**	**No**
Have the risks of COVID-19 and face to face treatment been discussed with the patient? **ie unable to maintain 2m distancing due to the nature of treatment (close contact / maintained touch).**	**Yes**	**If yes, does the patient consent to attending the face to face session?** **Yes / No** **Do they agree to follow pre-screening guidelines as below*** **Yes / No**	**No**
THERAPIST'S NAME	**JULIA KINSEY GOsC1483**	**THERAPIST'S SIGNATURE.**	**……**

***Prior to attending a face to face appointment, the patient must agree that if they experience any symptoms that may be due to COVID-19:**
ie. shortness of breath, continuous cough, unusual fatigue, loss of taste or smell
or they have been exposed to a person with COVID-19, they must cancel and reschedule their appointment for 14 days thereafter.