COVID-19
Client Declaration Form

Pre-screening is now a public health recommendation for clients prior to attending for treatment. This measure is an effort to minimise the risk of the spread of COVID-19 within our community and the clinic. On review of the form, your therapist may contact you and ask you not to attend the clinic at this time and will discuss a suitable future appointment for your treatment. Every question **must** be answered.

We have taken these extra measures to safeguard our clients prior to arrival. We kindly ask you to complete this declaration for the safety of you, our other clients, and therapists. Please return the fully completed declaration by email, photograph and return by text, or by post to the address below at least 24 hours prior to your appointment.

Appointment Date	
Client Name	
Contact Number	
Therapist Name	

PRE-TREATMENT SCREENING QUESTIONS (Please tick as appropriate)	**YES**	**NO**
Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days?		
Have you been in close contact with a confirmed or suspected case of COVID-19 in the last 14 days? (i.e. less than 2m for more than 15mins accumulative in 1 day)		
Have you or anyone in your household travelled abroad in the last 14 days? (apart from travel between Northern Ireland and Republic of Ireland)		
In the last 14 days, have you displayed any of the following symptoms: fever, high temperature, persistent coughing, breathing difficulties / shortness of breath, and / or loss of taste or smell?		
Have you been advised by a Doctor or the HSE to self-isolate at this time?		
Have you been advised by a Doctor or the HSE to cocoon at this time?		
Could you be classified as a person falling into the "at risk" group around whom additional HSE guidelines apply? (e.g. underlying health conditions which place you at increased risk)		

I understand that this information is required for the purposes of public health and will be kept on file for a 2-month period from the date of signing. I confirm that the above information is true and accurate from the date of signing. I understand that my personal information including my name and contact details may be shared with the Health Service Executive (HSE) for the sole purpose of contact tracing in line with public health guidelines only if requested.

Client Signature: _____ **Date**: ___/___/_____

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