CORONAVIRUS PRECAUTIONARY CHECKLIST FOR ALL PATIENTS & CLIENTS

Please read and complete this form and return to the sender a minimum of 48 hours prior to attending for your appointment. Compliance with this request is essential before you attend the practice*. If you have not been able to submit this form in advance then please do this upon your arrival at the practice.*

YOUR NAME: . . . . . .

DATE OF APPOINTMENT: . . . . . .

NAME OF PRACTITIONER: . . . . . .

1. Have you have been outside the UK in the last 14 days: YES/NO

   If YES, where? _____

2. Are you experiencing any of the following symptoms, or have had any of these in the last 14 days:

   Cough, temperature above 37.5c, shortness of breath, Chills, Sore throat, Loss of smell, Loss of taste, Headache, Diarrhea, Severe vomiting?

   YES/NO Symptoms:_____

3. Have you had any known contact with person/s confirmed as having COVID-19? YES/NO

   If YES, when? _____

ON YOUR ARRIVAL TO THE PRACTICE WE WILL TAKE YOUR TEMPERATURE USING AN ELECTRONIC EAR THERMOMETER. IF YOUR TEMPERATURE IS ABOVE 37.5C WE WILL NOT BE ABLE TO SEE YOU. WE WILL ASK YOU TO GO HOME AND FOLLOW NHS GUIDELINES.

Your temperature today was:_____

Signature*and Date _____

*Electronic submission of this form from a recognized email address constitutes your digital signature.