COVID-19 QUESTIONNAIRE

For face-to-face appointments

Client name	
DOB	

Date of planned appt.	
Location	Clinic ☐ Home visit ☐ Other ☐

Brief clinical explanation:	
Does the client wish to accept the appointment, understand the risks involved and the process that will be followed?	YES | NO
Is the client, or another household member, shielding?	YES | NO
Additional comments:	

Completed by		Date	

Within 12 hours of appointment:

Does the client have any of the following symptoms? • a new continuous cough • high temperature (37.8 degrees centigrade or higher) • loss of taste or smell	YES | NO YES | NO YES | NO
Has the client tested positive for COVID-19? Date of test	YES | NO
Does another household member have any of these symptoms?	YES | NO
Has the client been in contact with an individual suspected of having COVID-19 within the last 14 days?	YES | NO

Completed by		Date	

If the client answers YES to any of the above, the appointment will be cancelled, and relevant advice given.