**COVID-19 Emergency Treatment Consent Form**

I, (the patient), consent to receive emergency treatment from Paula Bright (Brightside Physio) during the COVID-19 outbreak.

I understand there is much to learn about the newly emerged COVID-19 including how it spreads and transmitted. I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets amongst close contacts.

I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19.

I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious. I understand that due to the unknowns of this virus, the number of other patients that have been seen by Paula Bright (Brightside Physio) and the nature of the procedures performed, that there is an increased risk of contracting the virus by receiving treatment from Paula Bright (Brightside Physio).

I understand that under the Chartered Society Physiotherapy guidelines, they do not recommend proceeding with any treatment that is non-essential at this time. I understand that the treatment I am receiving is an emergency because of the underlying pain, or conditions, that limit my normal day-to-day activities.

I confirm I am seeking treatment for a condition that meets these criteria. I understand that the symptoms listed below are representative of COVID-19:

● Fever

● Dry Cough

● Shortness of Breath

● Temperature

● Persistent pain or pressure in the chest

● Bluish lips or face

● Sudden loss of smell or taste

I confirm that I do not display or currently have any of the symptoms that are representative of COVID19, which are outlined above. I, nor anyone in my household is currently ‘shielding’ due to comorbidities/ vulnerabilities that make them more at risk of a) contracting COVID-19 or b) or have potentially impeded recovery from COVID19

I understand that all travelers arriving from a country or region with widespread ongoing transmission, as outlined by the CDC (Centre of Disease Control and Prevention), should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I have not travelled to any of the countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Guardian  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physio Practitioner Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_