Valid Consent to Treatment Form and Notice of Risk Assessment

With regard to the Risk of Transmission of Covid-19

Please read this consent form, discuss it with your therapist and if you wish to proceed with treatment sign where indicated at the end. Pages 1-4 are for your own use.

If the treatment is for a child under 16 years, the parent or legal guardian will complete and sign this consent form on the child's behalf.

During these times of uncertainty surrounding the global Covid-19 outbreak and the easing of lockdown, I wish to share this information with you and inform you of the steps I have taken to keep you and the rest of our community safe and healthy as I resume my therapy practice. Both my clients' and my own family's health and wellbeing has been, and continues to, be of the greatest importance to me.

New procedures

I am now taking extra precautions to maintain a healthy and safe environment for providing treatments. These are in line with current advice and guidelines from the UK Government, along with those laid out by my professional body, the Craniosacral Therapy Association (CSTA).

How the Covid-19 Virus spreads.

This virus is thought to spread mainly from person-to-person through close proximity (within about 6 feet) via moisture droplets produced through coughing, sneezing, heavy breathing or even talking. It can also be transferred through physical contact with surfaces such as door handles and clothing. It is now thought that people may be most contagious before and during the first week of developing symptoms. *So whilst I am taking all reasonable precautions to limit your risk of exposure to coronavirus, I cannot guarantee that there is no risk to you as a result of attending the clinic and/or receiving treatment.*

Therefore, I am requesting that if you :

- suspect you might be showing Covid-19 symptoms, or
- have tested positive for Coronavirus in swab tests,
- have been in contact in the past ten (10) days with anyone who has tested positive for Covid-19 or who is showing typical symptoms ...

... please follow NHS guidance and stay away from visiting the practice until at least one week has passed without you being aware of any symptoms.

Also any clients attending the practice should sign this consent form to confirm they are not presenting with any of the main symptoms of Covid-19 *(see box below)* . Likewise, I (Andrew Cook) also confirm that I am free of symptoms and have to my knowledge not been in contact within the last seven days with anyone who is infected or symptomatic. For full list see declaration below.

Recognised Covid-19 symptoms include:

- a high temperature within the ten (10) days **(feeling hot to touch on your chest and back)**
- a new, continuous cough **(coughing a lot for more than an hour or 3 or more coughing episodes in 24 hours or a worsening of a pre-existing cough)**
- a loss or change to your sense of smell or taste
- or have knowingly been in contact in the last ten (10) days with anyone who has been symptomatic of having Covid-19.

NHS Test and Trace

I am required to assist NHS Test-and-Trace with requests for data (including name, contact number, dates and times of visit) if needed, up to 21 days after the treatment, as this could help contain clusters of outbreaks. Public Heath Advice contact tracing staff will ask for these records only where it is necessary, either because someone who has tested positive for COVID-19 has listed my premises as a place they visited recently, or because my premises have been identified as the location of a potential local outbreak of COVID-19.

If I get a Test-and-Trace call, I would be asked to disclose anyone I have been with for more than 15 minutes. As a result, depending on the circumstances and length of time that has elapsed, you might be asked to be tested, to take extra care with social distancing or to self-isolate. This is a risk that we take in being in close contact for treatment sessions. *The information passed on will only be used where necessary to stop the spread of Covid-19. You may opt-out (if you do not want your details shared for the purposes of Test-and-Trace) by crossing out the relevant consent sentence (iv) below.*

Levels of risk

I believe my practice has a robust risk assessment with enhanced procedures for potential face-to-face contact with most clients who are at “Low” risk of serious infection if they contract Covid-19. High risk patients should already have been informed of their risk status directly by the NHS, and would normally be shielded. For those who are in the ‘at Moderate risk’ group (clinically vulnerable) the threshold for making a decision to provide non-mainstream care (i.e. come to my clinic for treatment) requires that we both recognise there is an increased level of risk, and should both take particular care in deciding whether treatment is appropriate at this time. You are deemed to be ‘at Moderate risk’ if you are :

• Aged 70 + • Non-severe Lung condition (Asthma, COPD, Emphysema or Bronchitis) • Are pregnant • Prone to Infections or have other immunological issues • Heart disease, diabetes, chronic kidney or liver disease • Neurological conditions (MS, Parkinson's, MND or Cerebral Palsy) • Take medicines that suppress the Immune System • Obese (have a BMI of 40 or more) (Source: NHS).

You are strongly advised to read and discuss this document carefully with me, your therapist, and then make an informed consent on attending the practice.

1. Your copy

Consent (please delete any sentences that do not apply)

i. I have read and understood the foregoing information.

ii. I confirm, to the best of my knowledge I am free of the symptoms of Covid-19 and have not recently been in contact with anyone who has.

iii. I understand that there is a risk of transmission of the corona virus leading to Covid-19 (the disease) as a result of attending this practice and / or receiving treatment.

iv. I agree for my details to be shared with Public Health Agency should they request them within 21days of my appointment

v. I agree, in the event that I develop symptoms of Covid-19 in the following 10 days after attending this practice, to inform the therapist of my changed status. This is to facilitate tracing anyone else who may have been potentially exposed to the corona virus. I will only undertake do this in the understanding that the therapist maintains client confidentiality at all times.

vi. I acknowledge I have discussed, or have been given the opportunity to discuss, with my therapist the nature of the contents of this consent. I have had the opportunity to ask all the questions I wish to at this time and that all my questions were answered to my satisfaction.

vii. I understand that I can choose to change my appointment to another date without incurring costs.

viii. I consent to the Craniosacral Therapy treatment offered or recommended to me today by my therapist.

Name: ____

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(Please print name of client) Client Signature or Parent/Carer signature on behalf of child if under 16

Name: ____

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(Please print name of Therapist) Therapist signature

(1) Date (First Signing) : _____/ ___ / 20____

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2. Copy held at clinic

Consent (please delete any sentences that do not apply)

ix. I have read and understood the foregoing information.

x. I confirm, to the best of my knowledge I am free of the symptoms of Covid-19 and have not recently been in contact with anyone who has.

xi. I understand that there is a risk of transmission of the corona virus leading to Covid-19 (the disease) as a result of attending this practice and / or receiving treatment.

xii. I agree for my details to be shared with Public Health Agency should they request them within 21days of my appointment

xiii. I agree, in the event that I develop symptoms of Covid-19 in the following 10 days after attending this practice, to inform the therapist of my changed status. This is to facilitate tracing anyone else who may have been potentially exposed to the corona virus. I will only undertake do this in the understanding that the therapist maintains client confidentiality at all times.

xiv. I acknowledge I have discussed, or have been given the opportunity to discuss, with my therapist the nature of the contents of this consent. I have had the opportunity to ask all the questions I wish to at this time and that all my questions were answered to my satisfaction.

xv. I understand that I can choose to change my appointment to another date without incurring costs.

xvi. I consent to the Craniosacral Therapy treatment offered or recommended to me today by my therapist.

Name: ____

____

(Please print name of client) Client Signature or Parent/Carer signature on behalf of child if under 16

Name: Andrew Cook

____

Therapist signature

(2) Date (First Signing) : _____/ ___ / 20____

Following page records re-confirmed understanding of Risk Assessment and Consent on subsequent treatment dates.

Re-confirmed understanding of Risk Assessment and Consent on subsequent treatment date(s), as previously signed:

Date and times of appointments:

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