COVID-19 PROTOCOL

Please read this consent form and if you wish to proceed with treatment sign where indicated at the end (you can do this on arrival at the clinic). If you have received this form by email, please reply before your appointment to confirm you've read the information & you've said NO to all the pre-screen questions, and you're happy to go ahead. Equally, please indicate if there's anything you wish to discuss with me.

What I'm doing to reduce risk:

- Pre-screening the suitability of all requests for treatment
- Wearing appropriate PPE including facemask
- Thoroughly sanitising and airing the room between appointments.
- Ensuring gaps of 30 mins between clients
- Rigorous hand-washing protocol before and after each
- Appointment times are strictly 45 minutes.

Please can you:

- Read and respond to this form before your treatment.
- Arrive at the clinic wearing your own mask.
- Arrive on time for your appointment.
- Bring a clean blanket for warmth if needed
- Wash/sanitize hands on arrival and on departure
- Observe 2M social distancing when not having treatment.
- Prepay before your appointment by bank transfer. My bank details are sort code 777433 acct number 04653968. Use your name and appointment date as a reference and forward me a copy of the transaction to my mobile 07971967185.
- Alternatively pay in cash - exact amount- £45- after treatment.

Pre-Screen for Coronavirus symptoms:

If you say YES to any of the following, please DO NOT attend your appointment: (You can re-schedule when appropriate and won't be charged a cancellation fee)

In the last 7 days – have you started to get a new persistent cough?
In the last 7 days – have you started to get a temperature or fever?
In the last 7 days – have you started to notice you can't smell or taste things properly?
In the last 14 days – have you been abroad?
In the last 14 days – has a member of your household had symptoms of COVID-19?
In the last 14 days – Have you been in contact with someone with suspected/confirmed COVID-19?
Likewise, I also confirm that I am free of the symptoms and have not recently (within the last 14 days) been in contact with anyone that has.

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. 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 below).

Levels of risk

For those who are in the 'at risk' groups ('high risk: clinically extremely vulnerable', or 'moderate risk (Source: https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/whos-at-higher-risk-from-coronavirus/) the decision to have Craniosacral therapy needs to be made in the light of your personal health issues.

You are strongly advised to consider carefully your level of personal risk and then make an informed consent on attending the practice.

Consent:

- I have read and understood the Risk Assessment.
- 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.
- I understand that there is a risk of transmission of coronavirus as a result of attending this practice and / or receiving treatment.
- I agree for my details to be shared with NHS Test and Trace should they request them within 21 days of my appointment.
- I agree, in the event that I develop symptoms of Covid-19 in the following 5 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 coronavirus. I will only undertake do this in the understanding that the therapist maintains client confidentiality at all times.
- 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.
- I understand that I can choose to change my appointment to another date without incurring costs.
- I consent to the Craniosacral Therapy treatment offered or recommended to me today by my therapist.

Name:
_____ _____
_____
(Please print name of client) Client Signature
Name:
_____ _____
_____
(Please print name of Therapist) Therapist signature

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

The following 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:
_____
_____
_____