Southfields
DENTAL CENTRE

Please take a moment to fill the following questions related to Covid 19 before attending the practice. We reserve the right to decline treatment if you are considered at risk of coronavirus.

Section 1 – COVID-19 Symptom checker

1. Do you have a new, continuous cough? Yes No
2. Do you have a high temperature of 37.8C or over? Yes No
3. Are you experiencing a change or loss in your normal sense of taste or smell? Yes No

Section 2 – Household

1. Have you or anyone in your household tested positive for coronavirus? Yes No
2. Are you still in the self/household isolation period? Yes No
3. Does anyone in your household have a new, continuous cough or a high temperature? Yes No
4. Is anyone shielding or vulnerable in the household? Yes or No

Section 3 – Clinically, extremely vulnerable people (high risk)

1. Have you been advised by your GP to shield, as a clinically, extremely vulnerable person? Yes No
   Please provide details:

Section 4 – Clinically vulnerable people (moderate risk)

1. Do you have a health condition which puts you in the clinically vulnerable, moderate risk of contracting coronavirus? Yes No
   For example:

- pregnancy
- over 70
- diabetes
- underlying lung condition that is not severe, such as asthma
- heart disease
- liver disease
- a condition affecting the brain or nerves, such as Parkinson's
- a condition which means you are at high risk of getting infections
- taking medicine that can affect your immune system, such as low dose steroids
- have a BMI of 40 or above

Section 5 – NHS Test and Trace

1. Have you been contacted by the NHS Test and Trace that you have been in contact with a person with Covid-19? Yes/No
2. Have you been tested for Covid 19? Yes or No
   If yes what was the result (attach a copy if available)
3. Have you had antibody testing for Covid 19? Yes or No
   If yes please give details and attach a copy of the results

I verify that the information provided above is accurate at the time of completing this form and I have completed this to the best of my knowledge.

I confirm that I am not a high-risk patient and consent to treatment being undertaken by my dentist and wish to proceed with treatment and fully understand any risks involved.

Patient Signature

Date

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