COVID-19 Patient Intake Consent

For Registered Massage Therapy

Part 1: Covid-19 Assessment Survey:

Yes / No	Have you or your close contact been tested for COVID-19?
Yes / No	If Yes, is the result Positive?
Yes / No	Are you experiencing any of the following: • Severe difficulty breathing (e.g. struggling to breathe or speaking in single words) • Severe chest pain • Having a very hard time waking up • Feeling confused • Losing consciousness
Yes / No	Are you experiencing any of the following: • Mild to moderate shortness of breath • Inability to lie down because of difficulty breathing • Chronic health conditions that you are having difficulty managing because of difficulty breathing
Yes / No	Are you experiencing cold, flu or COVID-19-like symptoms, **even mild ones**? (Symptoms include: fever, chills, cough, shortness of breath, sore throat and painful swallowing, stuffy or runny nose, loss of sense of smell, headache, muscle aches, fatigue or loss of appetite. For younger children, purple colour rashes over the body.)
Yes / No	Have you travelled via a plane or cruise ship or traveled outside of BC in the past 14 days?
Yes / No	Did you provide care or have close contact with a person with confirmed COVID-19, except in a PPE controlled medical setting? Note: This means you would have been contacted by your health authority's public health team.

Source: https://bc.thrive.health/covid19/en

All of the above answers are truthful to date. Date: _____ Initial _____

Part 2: I, as a patient, for my RMT at this clinic

If I have answered "YES" to ANY of the above statements, I agree that for my safety, and those of others, I cannot attend my RMT appointment, and I will cancel my appointment immediately. I will take all necessary steps recommended by https://bc.thrive.health/covid19/en

Initial _____

If I have answered "NO" to ALL the statements in Part 1, I confirm that:

- I will cancel my appointment(s) immediately if/when any of the above answers change.
- I also must follow 14 days quarantine before I can be assessed again prior to my bookings.

- I understand that late cancellation will not apply when symptoms appear within the 24-hr period.

Initial _____

Part 2: I, as a patient, for my safety, for my RMT at this clinic**,** and those of others, agree to:

Yes / No	wear a mask or facial coverings during my visit; and
Yes / No	wash my hands upon entry/re-entry into my RMT Clinic and promptly after my treatment is finished; and
Yes / No	wait in my vehicle or outside and only come in 5 minutes prior to my appointment time; and
Yes / No	only come to the clinic ALONE, unless I physically require a caregiver; and
Yes / No	anyone who comes into the clinic with me (as a caregiver) has to follow ALL of the protocols like I do, including but not limited to wearing a face mask throughout, hand washing, physical distancing, filling out **COVID-19 Patient Intake Consent** prior to entering the clinic; and
Yes / No	only come with minimum personal belongings to help prevent cross contamination and prevent the spread of COVID-19; and
Yes / No	strictly follow the 6 feet physical distancing rules to help maintain the safety of myself and the others in the clinic; and
Yes / No	leave promptly after my appointment; and
Yes / No	read the new protocols and follow all of the necessary steps to protect myself and anyone in this clinic, to help prevent the spread of COVID-19.

If I have answered "NO" to ANY of the statements in Part 2, for my RMT and their family's health concerns, and those of others, I will be referred to see other RMTs or to other clinics.

Initial _____

Part 3: I, as a patient of my RMT at this clinic, if I have answered "YES" to ALL of the above statements in Part 2, I understand that:

Yes / No	COVID-19 virus has a long incubation period whereby carriers of the virus may not show symptoms and can still be contagious; and
Yes / No	due to the visits of other patients, or simply by being in this clinic / building, I have elevated the risk of contracting COVID-19; and
Yes / No	while my RMT is following all of the health and safety guidelines outlined by the Registered Massage Therapists Association of BC, the College of Massage Therapists of BC, and the Provincial Health Officer and that they are taking all reasonable precautions to clean and disinfect the clinic and all the surfaces within the treatment room, there are no guarantees that I may not come into contact with COVID-19; and
Yes / No	I am fully aware of and fully responsible for any allergic reactions that may arise due to my exposure of government approved disinfectants at this clinic; and
Yes / No	I may discontinue the Registered Massage Therapy treatment(s) at any point of time if I feel it is not safe; and
Yes / No	for me to receive Massage Therapy Treatments, my RMT will not be able to practice social distancing.

If I have answered "NO" to ANY of the statements in Part 3, I will not seek RMT treatment at this time at this location.

Initial _____

Part 4: I, as a patient of my RMT at this clinic, if I have answered "YES" to ALL of the above statements in Part 3, I voluntarily:

Initial	give my RMT permission to contact me directly the day before my upcoming appointments, and I will truthfully answer questions in Part 1 of this consent form each time; and
Initial	release my Registered Massage Therapist and the Clinic of any liability if I were to contract COVID-19; and
Initial	give this clinic my permission to share my personal information for contact tracing when there is a confirmed positive; and
Initial	give my RMT the right to refuse to provide treatment when it is not safe for me to receive or not safe for my RMT to perform.

Part 4: Summary

I, _____, as a patient of my RMT at this clinic, understand that ANY massage therapy treatment involves some risk of COVID-19 transmission.

I weigh my ongoing RMT treatments as medically necessary during this COVID-19 pandemic, I consent to treatment of Registered Massage Therapy despite some risks of COVID-19.

I verify that the information I have provided on this form is truthful and accurate. I have read and fully understand and agree to follow ALL the above details. I voluntarily give the consent to receive on-going Massage Therapy treatment(s) during this COVID-19 pandemic.

_____
SIGNATURE OF PATIENT

Printed Name: _____

Date: _____