DR. DEBBIE LEE
TCM, ACUPUNCTURIST & HERBALIST

**COVID-19 SCREENING QUESTIONNAIRE AND CONSENT FORM**

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

**COVID-19 Questionnaire:**

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by BC Ministry of Health:

• Fever > 38°C • Cough • Sore Throat • Runny Nose • Shortness of Breath • Difficulty Breathing • Flu-like symptoms

_____ (Initial)

I verify that I have not returned to BC from any country or province outside of BC whether by car, air, bus or train in the past 14 days.

_____(Initial)

I have not been in close contact with a person with acute respiratory illness who has been to a COVID-19 impacted area nor have been in a large group setting in the last 14 days where someone has been confirmed to have COVID-19.

_____(Initial)

I understand that the BC Ministry of Health has asked individuals to maintain physical distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive acupuncture or massage treatment.

_____(Initial)

I understand that I am going for an elective treatment that may not be urgent or medically necessary. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

_____ (Initial)

I understand that due to the characteristics of the novel coronavirus, and the characteristics of acupuncture and massage treatments, that I have an elevated risk of contracting the novel coronavirus simply by being in a health care clinic.

_____ (Initial)

I acknowledge that this clinic is taking extra precautionary measures to prevent the possible transmission of the novel coronavirus. Measures that include extra sanitizing procedures that will be enacted after every patient. Office scheduling has also been modified to limit interactions and contact of one patient to others.

I verify the information I have provided on this form is truthful and accurate. I intend this consent to cover the entire course of care from all providers in this office.

_____

SIGNATURE OF PATIENT

_____ _____

NAME PRINTED DATE