Hastings Location
2738 East Hastings Street
Vancouver, B.C., V5K 1Z9
Telephone: 604-251-6437
Fax: 604-251-7406

Victoria Location
5458 Victoria Drive
Vancouver, B.C., V5P 3V8
Telephone: 604-327-1400
Fax: 604-327-3340

SUNRISE PHYSIOTHERAPY
East Hastings • Victoria Drive

COVID-19 DECLARATION AND CONSENT FORM

Due to the highly infectious nature of the current pandemic virus COVID-19, all patients must complete this COVID-19 declaration and consent form prior to first appointment and give verbal confirmation that all information is the same for every single subsequent appointment.
Please CIRCLE your answers.

1. ARE YOU CURRENTLY POSITIVE FOR THE COVID-19 VIRUS? YES/NO/AWAITING RESULTS
FULLY RECOVERED DATE:

2. HAVE YOU DONE THE ONLINE COVID SELF ASSESSMENT IMMEDIATELY PRIOR TO THIS APPOINTMENT?
YES/NO RESULT? _____

3. I AGREE TO DO THE ONLINE COVID SELF ASSESSMENT IMMEDIATELY PRIOR TO ALL MY SUBSEQUENT APPOINTMENTS.
YES/NO

4. DO YOU HAVE ANY SYMPTOMS CONSISTENT WITH ILLNESS (SORE THROAT, COUGH, chest tightness, DIFFICULTY BREATHING, FEVER, chills, fatigue, muscle aches, painful swallowing, stuffy or runny nose, loss of smell or taste)
YES (circle the symptoms that apply to you)/ NO

5. HAVE YOU TRAVELLED OUTSIDE OF BRITISH COLUMBIA IN THE LAST 14 DAYS? YES/NO

6. HAVE YOU BEEN IN CONTACT WITH SOMEONE OR A LOCATION THAT HAS HAD A CONFIRMED COVID-19 CASE IN THE LAST 14 DAYS?
YES/NO/YES WITH PPE IN A CONTROLLED MEDICAL SETTING

7. I AM ABLE TO WEAR A BARRER FACIAL MASK SAFELY DURING TREATMENT, TO PROTECT MYSELF AND STAFF AT THE CLINIC.
YES/NO WHY NOT? _____

8. I UNDERSTAND THAT MY THERAPISTS AND THE CLINIC ARE FOLLOWING AN ELEVATED SAFETY PROTOCOL TO REDUCE AND MITIGATE RISK, BUT ACKNOWLEDGE THAT RISK CANNOT BE REDUCED TO ZERO. YES/NO

9. I CONSENT TO TEMPORARILY DISREGARD THE PHYSICAL DISTANCING REQUIREMENT SO I CAN RECEIVE THERAPEUTIC TREATMENT FOR THE OVERALL BETTERMENT OF MY HEALTH AND WELL- BEING. I AM AWARE OF THE RISKS AND BENEFITS OF DOING SO. YES/NO

I, _____ have answered all the questions truthfully and confirm the information is accurate pertaining to my health. I consent to physical therapy treatment where physical distancing will not be possible, during the COVID-19 pandemic. I understand the risks associated to close contact with others and by signing this, I indemnify Sunrise Physiotherapy Clinic and their Therapists if I contract COVID-19 virus as a direct result of my treatment.

SIGN_____ Date signed: _____