



HAIR TO WARE

GIVING YOU BACK YOUR SPARKLE

COVID-19 Pre - Appointment Triage Form

NOTE: Please complete and return by email one day before your appointment

Client Information

NAME:	ADDRESS:
EMAIL:	DOCTORS NAME & ADDRESS:
DATE:	TELEPHONE:
HOW DID YOU HEAR OF US:	

COVID-19 QUESTIONNAIRE (Circle Box that applies)

Have you tested positive for COVID-19 in the last 7 days?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Are you waiting for a COVID-19 test or the results?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you have the following symptoms? New, continuous cough, High temperature or Fever.	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you live with someone who has either tested positive for COVID-19 or had symptoms of COVID-19 in the last 14 days?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you visited Hospital within the last two weeks? If so, what department/ward?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you need anyone to accompany you to appointment? If yes, please state the reason and details of the person who will be attending with you.	<input type="checkbox"/> Y	<input type="checkbox"/> N
I agree to Hair to Ware staff taking and recording my temperature with a hand held thermometer, from a safe distance.	<input type="checkbox"/> Y	<input type="checkbox"/> N
I agree to update Hair to Ware if I start to show symptoms or someone I live with displays symptoms over the next 24 days.	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered **YES** to any questions, please give details below:

Print Name **Signature**..... **Date** / /2020