

ASSESSMENT • TREATMENT • WORKSHOPS

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**COVID-19 CONSENT FORM TO SUPPLEMENT CONSENT TO CONSULTATION /
TREATMENT / PROCEDURE**

I, the undersigned guardian of _____ (Child's name and surname)
hereby state that I understand, and agree to the following:

1. I am authorized to provide this consent.
2. This consent form supplements the general consent I provided when agreeing to health care, treatment, investigation, an examination and/or to a procedure, and the risks and costs thereof.
3. COVID-19 is a virus that is highly infectious, and can spread from person to person, and survive on surfaces. I understand that as a patient / parent / caregiver / authorized person, I have a responsibility to ensure that all rules set by the National Institute for Communicable Diseases (NICD - <https://www.nicd.ac.za>) and the National Department of Health, are followed. Accompanying persons at therapy must adhere to physical distancing rules at all times, with a cloth face mask on, at all stages.
4. Department of Health Guidelines identify certain patients as vulnerable should they contract COVID19, and it is understood that this may influence decisions in relation to any healthcare to be rendered.

Initial: _____

5. It is understood and agreed to, that no guarantees can be made that the virus will not be transmitted in a practice, or in a health facility. It is also understood that asymptomatic persons may transmit the virus.

6. All patients and accompanying or authorized persons will be required to complete a screening survey prior to the consultation, treatment and/or procedure taking place. The results may necessitate that the patient and/or accompanying person be referred for a COVID-19 test or at very least non attendance at therapy until such time that they will pass the screening. It is understood that the results of a COVID-19 test, or any screening that reveals a person who might have been exposed to the virus, must by law, be reported to the authorities (the NICD). This includes the duty to supply details of all contacts.

7. The Practice may require adherence to specific protocols to protect the therapist / the patient, and any accompanying person. Practice protocols include that only one patient will be allowed in the practice with each therapist at a time. The healthcare provider will advise on what is expected of a patient before, during and after health care is rendered.

8. Please DO NOT bring your child to therapy if they, or any family member in the house, are feeling ill in any way or have cold / flu- like symptoms or any family member in the house is in quarantine due to exposure to COVID -19 virus.

9. Specific therapy treatments require the therapist in close proximity to the patient. The child may be requested to remove his/her face mask or use a visor. The therapist may wear different types of protective clothing, depending on the nature of work and may thus wear a visor instead of a mask and / or make use of a Perspex screen between herself and the client / patient.

10. The therapist will as part of the booking, consultation and/or treatment processes advise and communicate as to what is required of patients and/or accompanying persons, and such patients and persons agree to adhere to such advisories and release the Practice from legal liability should they decline to do so.

Initial: _____

11. If health care (investigation, consultation, treatment and/or consultation) is refused or delayed by the patient/authorized person, despite being recommended by the health care provider, the patient / parent / authorized person confirms that s/he has been informed of the implication of such refusal or delay and releases the health care provider from legal liability should any harm result from such a refusal or delay.

Guardian 1 full names & surname: _____

Identity number: _____

Signature: _____

Date: _____

Guardian 2 full names & surname: _____

Identity number: _____

Signature: _____

Date: _____