

Covid Questionnaire and Patient Agreement

Please complete and return this questionnaire to justincarter@nhs.net

Are you proven to have had Covid-19 in the past (by swab or blood test results)? **Yes** **No**

If yes, by what means and when? _____

In the last two weeks have you or your co-habitees been unwell with any symptoms? **Yes** **No**

If Yes, detail what symptoms and when _____

In the last two weeks have you or any of your co-habitees been self-isolating /shielding? **Yes** **No**

If yes, please provide details: _____

What is the travel distance between your residence and the Hospital (TS19 8PE)? **Yes** **No**

Distance (Miles) _____

Do you have access to a car for the Journey (Public transport to be avoided)? **Yes** **No**

What is your Licence type and what flying / ATCO duties do you perform?

From any existing medical certificate, list the expiry dates of the respective classes of medical:

Are you able to use the CAA extension (see www.pilotmedical.co.uk 'Covid issues')? **Yes** **No**

By signing this document you agree that:

You will report any change in circumstances (particularly symptoms) before the medical takes place.

You will attend alone (unless a chaperone is required in which case a member of your household will attend to chaperone with you).

You will be fully informed of any change in the health status of the AME.

You will undergo a temperature check at the beginning of the medical examination.

You will be required to wear a facemask (which will be provided) during the medical.

You will have contact with one person (the AME) who will wear appropriate PPE.

Appropriate precautions will have been taken in the Covid negative clinical area where the medical will take place (cleaning, disinfection etc).

Physical distancing will be maintained throughout except where physical examination requirements prevent distancing at which time risk will be mitigated by PPE use.

The medical can be cancelled by either party at any time.



Dr Justin Carter
Consultant Cardiologist
Aviation Medical Examiner

Patient Print Name

Patient Signature

Date