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MAXILLO-FACIAL AND ORAL SURGEON

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"**committed to quality specialist care in the best interest of our patients**"

COVID-19 Pandemic Treatment Consent Form

I _____, knowingly and willingly consent

to have elective or emergency treatment completed during the COVID-19 pandemic.
I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious.

- It is impossible to determine per patient/person.
- Procedures take place with the patient in very close proximity to the service provider.
- This potentially exposes the patient and the operator to saliva and to coolant water spray, which may spread the disease.
- The ultra-fine nature of the spray and droplets may linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.
- I understand that due to the frequency of visits of other patients, the characteristics of the virus, and the characteristics of procedures, that I have an elevated risk of contracting the virus simply by being in a treatment facility.
- I confirm that I am not presenting with any of the following symptoms of COVID-19 listed: Fever • Shortness of Breath • Dry Cough • Runny Nose • Sore Throat
- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The NICD recommends social distancing and as this is not possible with treatment I agree to undergo any pre and/or post-testing, or quarantine, or any other measures as needed**, <u>at my own cost.</u>**
- I verify that I have not travelled in the past 14 days either internationally or domestically and have not been in any physical contact with any person(s) known to have been positively affected by COVID- 19.

I HAVE READ THIS DOCUMENT FULLY AND UNDERSTAND THE CONTENTS.

I AM LEGALLY EMPOWERED TO PROVIDE THIS CONSENT AND INDEMNITY AGAINST ANY PATRIMONIAL/NON-PATRIMONIAL/ANY OTHER CLAIMS, AGAINST ANY MEMBER OF THE HEALTH TEAM, THE FACILITY OR ANY OTHER PERSON NEEDED, FOR THE TREATMENT THAT I HAVE CHOSEN TO ACCEPT.

Name: _____ I.D. No: _____

Signature: _____ Date: _____