COVID-19 Pandemic Dental Treatment Consent

Patient name: ______________________________

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that dental procedures create water and/or blood spray which is one way that the novel coronavirus can spread. ________ (initial)

Do you have **ANY** of the following symptoms of COVID-19 identified by the Ontario Ministry of Health: • Fever • New onset of cough • Worsening chronic cough • Sore throat • Difficulty swallowing • Difficulty breathing • Shortness of breath • Chills • Headaches • Pink eye (conjunctivitis) • Decrease or loss of sense of taste or smell • Unexplained fatigue/malaise/muscle aches (myalgias) • Runny Nose/nasal congestion without other known causes • Nausea/vomiting/diarrhea/abdominal pain • **If you are 70 years of age or older:** are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions	NO _________ **If **YES** to any of these symptoms please circle all applicable**

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. ________ (initial)

I confirm I know that there are categories of people who are considered to be high risk. I understand the high risk category factors are being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder. ________ (initial)

OR

I fall into the following high risk categories (_________________________) and my dentist and I have discussed the risks, and I have agreed to proceed with treatment. ________ (initial)

I confirm that I do not currently have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19 ________ (initial)

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. ________ (initial)

I understand that any travel from any country outside of Canada, including travel by car, air, bus or train, significantly increases my risk of contracting and transmitting the novel coronavirus. The Ontario Ministry of Health requires self-isolation for 14 days from the date a person has returned to Canada. ________ (initial)

I confirm that I have not had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 day's ________ (initial)

I understand that the Ontario Ministry of Health has asked individuals to maintain physical distancing of at least 2 meters (6 feet) and it is not possible to maintain this distance and receive dental treatment. ________ (initial)

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed dental treatment completed during the COVID-19 pandemic.

____

SIGNATURE OF PATIENT (or Legal Guardian)

Printed Name: ____________________________________ Date: ________________________