COVID – 19 INFORMED CONSENT TO TREAT

I understand that the novel coronavirus (SARS-CoV-2) which can cause COVID-19 has been declared a global pandemic World Health Organization. I further understand that SARS-CoV-2 is extremely contagious and may be contracted from various sources. I understand SARS-CoV-2 has a long incubation period during which carriers of the virus may not show symptoms instantly contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of healthcare during a pandemic. Given the current limitations of SARS-CoV-2 testing, I understand determining who has infected with SARS-CoV-2 is exceptionally difficult

To proceed with receiving care, I confirm and understand the following (initial in all seven places provided)

Initial Below

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which SARS-CoV-2 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the SARS-CoV-2 pandemic, I agree to proceed with my desire treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contacting SARS-CoV-2 simply by being in a healthcare office. _____
- I confirm I am not experiencing any of the following symptoms of that are listed below:
  * Fever * Dry cough *Sore throat
  * Shortness of breath *Runny nose * Loss of taste or smell _____
- I understand travel increases my risk of contracting and transmitting the SARS-CoV-2 virus. I verify that I have not in the past 14 days, travelled: 1) outside of Canada to countries that have been affected by SARS-CoV-2; or 2) domestically within Canada by a commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of SARS-CoV-2. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with SARS-CoV-2 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with SARS-CoV-2 through this elective treatment and give my express permission to you and the staff of your office to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH A FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION OF CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONSIDERATION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

	Signature of	Signature of
Signature _____	Parent / Guardian _____	Witness _____
Name _____	_____	_____
Date _____	_____	_____ _____