COVID-19 Pandemic Dental Treatment Consent Form

Patient name:		
CMOH Order <u>05-2020</u> legally obligates any person who has the following core shortness of breath, runny nose, or sore throat (that is not related to a pre-exicondition) to be in isolation (quarantine) for 10 days from the start of symptor resolve, whichever takes longer, or they receive a negative COVID Test. If they these symptoms, it is suggested they complete the <u>COVID-19 Self-Assessment</u> they should be tested.	sting illness or health ns, or until symptoms are exhibiting any of	
I understand the novel coronavirus causes the disease known as COVID-19. I understand the nove coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious (Initial)		
I understand that due to the frequency of visits of other dental patients, the novel coronavirus, and the characteristics of dental procedures, that I have contracting the novel coronavirus simply by being in a dental office.	an elevated risk of	
For Patients over 18, I confirm that I am not presenting any of the following COVID-19 as identified by Alberta Health Services:	g core symptoms of	
• Fever > 38°C	(Initial)	
Recorded Temperature:	-	
• Cough	(Initial)	
Sore throat	(Initial)	
 Shortness of breath 	(Initial)	
• Runny Nose	(Initial)	
For patients under 18, I confirm that they are not presenting any of the foll	owing core symptoms of	
COVID-19 as identified by Alberta Health Services:		
• Fever > 38°C	(Initial)	
Recorded Temperature:	-	
• Cough	(Initial)	
 Loss of sense of taste or smell 	(Initial)	
 Shortness of breath 	(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 to my knowledge I am not currently positive for the novel coronavirus(Initial)
I confirm I am not waiting for results of a laboratory test for the novel coronavirus(Initial)
I confirm that understand that if I have to quarantine or have tested positive for COVID-19 I cannot enter a healthcare facility for 10 days or until my symptoms have resolved, whichever is longer (Initial)
I verify that I have not returned to Alberta from any country outside of Canada whether by car, air, bus, boat or train in the past 14 days (Initial)
I understand that any travel from any country outside of Canada, including travel by car, air, bus,
boat or train, significantly increases my risk of contracting and transmitting the novel coronavirus.
Alberta Health Services require self-isolation for 14 days from the date a person has returned to Canada (Initial)
I confirm that I am not a participant in the International Border Pilot Testing Program(Initial)
Or, I have participated in the International Border Testing Program and understand I am not permitted to enter a healthcare facility for 14 days after return from travel (Initial)
I understand that Alberta Health Services has asked individuals to maintain physical distancing of a least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment (Initial)
I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by Alberta Health, the Communicable Disease Control or any other governmental health agency (Initial)
OR
I verify that I am a healthcare worker who has worn appropriate PPE (Initial)

LIST of DENTAL TREATMENT	
·	d on this form is truthful and accurate. I knowingly and ted dental treatment completed during the COVID-19
SIGNATURE OF PATIENT	
Printed Name	Date