COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

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. Given the current limits of COVID-19 virus testing, it is impossible to determine who is infected with COVID-19 and who is not. _____ (initial)

Some anesthesia procedures create aerosols which is how the disease can be transmitted. It is unclear as to how long the ultra-fine nature of the spray may linger in the air, which can transmit the COVID-19 virus. _____ (initial)

I understand that due to the scheduling frequency of appointments of other surgical patients, the characteristics of the virus, and the characteristics of anesthesia and surgical procedures, that I have an elevated risk of contracting the virus simply by being in a surgery office. _____ (initial)

I recognize that the physician, nurses, and all the staff at _____ (name of practice) and _____ (name of facility) are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. _____ (initial)

I confirm that I am NOT presenting any of the following symptoms of COVID-19 that are listed below:

- Fever over 100 degrees Fahrenheit
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- Chills / shaking chills
- Nausea, vomiting, diarrhea
- Loss of smell or taste
- Sudden onset severe headache or fatigue

_____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and that this is not possible during the actual surgical procedure. _____ (Initial)

I verify that I have NOT traveled outside of the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)

I verify that I have NOT traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____ (Initial)

I understand that this facility may cancel/reschedule my appointment if I am exhibiting symptoms of COVID-19, recently traveled abroad or was subject to a known exposure event. _____ (Initial)

I am knowingly and willingly consenting to these procedures for myself with the full understanding and disclosure of such risks and alternatives associated with the COVID-19 pandemic, and all of my questions were answered to my satisfaction.

_____ _____
Signature of Patient or Guardian Date

_____
Witness