COVID-19 Emergency Consent Form

Background information as of 22 June 2020.

I understand that based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to person via respiratory droplets by close contact. I understand that close contact can occur from being within approximately 6 feet (2 meters) of someone with COVID-19, for a prolonged period of time or by having direct contact with infectious secretions with COVID-19. I understand that carriers of COVID-19 may not show symptoms but may still be highly contagious.

I understand that due to unknowns of this virus, the number of other patients that have been in the practice and the nature of the procedures performed here, that I have an increased risk of contracting the virus by being in the practice and by receiving treatment in the practice.

I understand that the treatment I am receiving is an emergency /essential because of the underlying pain, or conditions that limit my normal day-today activities. I confirm I am seeking treatment for a condition that meets these criteria.

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent Pain or Pressure in the Chest
- Bluish Lips or Face
- Loss of Taste and Smell

I understand that every precaution has been taken to avoid contamination.

Self-Certification Form

Please answer the following questions by answering/highlighting (Y) or (N)

1. Do you have **now or in the last 7 days** any of the symptoms that are representative of COVID-19 (outlined in Page 1 above). (Y) (N)

2. Have you to the best of your knowledge been in contact with anyone with COVID-19 symptoms in the last 14 days? (Y) (N)

3. Have you, to the best of your knowledge, had close contact with an individual diagnosed with COVID-19 in the past 14 days.

4. Are you in a high risk group for COVID-19?
   (Y) (N)

5. Do you have any underlying health conditions that affect your respiratory system?
   (Y) (N)

If **YES**, please circle or detail below…
Asthma / Chronic Obstructive Pulmonary DIsease (COPD) / Bronchitis / Emphysema / Cystic Fibrosis / Bronchiectasis / Pneumonia / Pleural Effusion
Other, please state here:

_____
_____

6. Do you have any other health or medical conditions that we at The Jane Harris Clinic should be aware of?
   (Y) (N)

If **YES**, please state here:

_____
_____

7. Have you travelled to any countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days.
   (Y) (N)

8. Do you understand the information on this consent and agree to treatment?
   (Y) (N)

DECLARATTION
I solemley and sincerely declare thet the information provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue or false, then I am aware that I can be prosecuted for making a false declaration.

I _____(the patient), consent to receive emergency treatment from Jane Harris at The Jane Harris Clinic on _____(date of appointment).