COVID-19 Emergency Consent Form

I understand there is still much to learn about the newly emerged COVID-19 including how it spreads and is transmitted.

I understand that based on what is currently known at this time, about COVID-19 the spread is thought to occur mostly from person-to person via respiratory droplets amongst 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. However with the new mutattion, this may be different , as it is much more transmissable.

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 CSP regulation guidelines do not recommend proceeding with any treatment that is non-essential at this time.

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
- Aching in the limbs

I confirm that I do not display or currently have any of the symptoms that are representative to COVID-19 (outlined above).

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

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

1. Have you been in contact with anyone with COVID-19 symptoms in the last 14 days? (Y) (N) (IF YES when was the contact)

2. Have you had a COVID- 19 test in the last 14 days? If so what was the result (Y)(N) (Result)

3. Have you had any COVID-19 symptoms in the last 7 days?
   (Y) (N)

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:
_____
_____

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:
_____
_____

I confirm that I have not traveled to any countries or regions with widespread ongoing transmission (Level 3 Travel Health Notice) in the past 14 days. _____ (Initial)

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days.

I consent to treatment in light of the potential risk I face of contracting COVID-19.

DECLARATTION
I solemley and sincerely declare that the information I have 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).