COVID-19 Pandemic Dental Treatment Consent Form

Patient name: _____

The novel coronavirus (SARS-CoV-2) causes the disease known as COVID-19. CMOH Order *39-2021* legally obligates any person who has the following core symptoms of cough, fever, shortness of breath, loss of taste or smell, runny nose, or sore throat (that is not related to a pre-existing illness or health condition), or tests positive for COVID-19, to be in isolation for 10 days from the start of symptoms, or until symptoms resolve, whichever takes longer; or, until testing negative for COVID-19. If they are exhibiting any of these symptoms, it is suggested they complete the *COVID-19 Self-Assessment online tool* to determine if they should be tested.

I understand the legal obligation stated above, set out in the CMOH Order *39-2021*._____ (Initial)

I understand that according to CMOH Order 44-2021, I am required to wear a mask while in the dental facility, except when receiving dental treatment. _____ (Initial)

I understand that due to the frequency of visits of other staff, dentists and dental patients, the characteristics of SARS-CoV-2, and the characteristics of dental procedures and that many dental procedures generate aerosols that I have an elevated risk of contracting COVID-19 simply by being in a dental office. _____ (Initial)

I confirm I know that there are categories of people who are considered to be high risk of contracting COVID-19. I understand the high risk category factors include: being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes, any auto-immune disorder, and immunocompromised. _____ (Initial)

I understand the novel coronavirus can take up to 14 days to cause symptoms and that some people who get COVID-19 only have minor symptoms or do not have symptoms at all, but could still be infectious. _____ (Initial)

I understand that Alberta Health Services has asked individuals to maintain physical distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment. _____ (Initial)

I understand completion of a COVID-19 Pandemic Screening prior to receiving any dental treatment is a measure to protect myself, other patients of the clinic and the staff. _____ (Initial)

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. _____ (Initial)

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SIGNATURE OF PATIENT or GUARDIAN/CAREGIVER

Printed Name_____ Date_____