COVID-19 Pandemic Screening & Dental Treatment Consent Form

Patient name: _____

Ora Dental is a healthcare facility with many dental procedures generating aerosols, and we have several patients who may be at more risk due to their age or compromised health.

I understand that despite the removal of most public health measures for COVID-19, Ora Dental will continue to require screening, masks and social distancing in order to keep all our staff and patients safe by preventing the spread of COVID-19 and other respiratory illnesses. _____ (Initial)

I confirm that I am not presenting any of the following core symptoms of COVID-19 as identified by Alberta Health Services:

- Fever > 38°C _____ (Initial)
  Recorded Temperature: _____ °C
- Cough _____ (Initial)
- Shortness of breath _____ (Initial)
- Runny Nose _____ (Initial)
- Sore throat _____ (Initial)
- Loss of taste or smell _____ (Initial)

CMOH Order *02-2022* 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 5 days (fully vaccinated) / 10 days (not fully vaccinated) from the start of symptoms, or until symptoms resolve, whichever takes longer; for fully vaccinated, following isolation, wear a mask at all times when around others outside of home for up to 5 more days. If symptomatic but testing negative for COVID-19 should still stay home and away from others until symptoms resolve.

I confirm that (*applies to all*):

- I am **not** currently positive for COVID-19.
- I am **not** waiting for results of a COVID-19 laboratory test.
- I have **not** been a close contact of, or live with someone, who has tested positive for COVID-19 within the last 14 days.
- If I am a healthcare worker: I have worn appropriate PPE when working in close contact of someone who has tested positive for COVID-19.

_____ (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.

_____

SIGNATURE OF PATIENT

Printed Name_____ Date_____

Updated April 1, 2022