COVID-19 Pandemic Dental Treatment Consent Form

Patient name: ___________________________________

CMOH Order 05-2020 LEGALLY obligates any person who has the following cough, fever, shortness of breath, runny nose, or sore throat (that is not related to a pre-existing illness or health condition) to be in isolation (quarantine) for 10 days from the start of symptoms, or until symptoms resolve, whichever takes longer. 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 novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. ___________ (Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental clinic. ___________ (Initial)

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

- Fever > 38°C ___________ (Initial)
  Recorded Temperature:______________________
- New cough or worsening chronic cough ___________ (Initial)
- Sore throat or painful swallowing ___________ (Initial)
- New or worsening shortness of breath ___________ (Initial)
- Difficulty Breathing ___________ (Initial)
- Flu-like symptoms ___________ (Initial)
- Runny Nose ___________ (Initial)

Fill out this section ONLY IF you have any of the risk factors listed here:

65 years of age or older
Heart disease
Lung disease
Kidney disease
Diabetes
Any auto-immune disorder

I understand that if I fall into any of the high risk categories above that I still agree to proceed with dental treatment. ___________ (Initial)

CONTINUED ON REVERSE →

I confirm that to my knowledge I am not currently positive for the novel coronavirus. ___________ (Initial)

I confirm I am not waiting for results of a laboratory test for the novel coronavirus that was ordered due to contact tracing or because I had identified risk factors. ___________ (Initial)
Please note: *Any individual who has gone for COVID-19 testing by his/her own choice as an asymptomatic individual does <u>not</u> need to indicate that here.*

I verify that I have not returned to Alberta from any country outside of Canada whether by car, air, bus, boat or train in the past 14 days. ___________ (Initial)

I understand that any travel from any country outside of Canada, including travel by car, air, bus, boat or train, significantly increases my risk of contracting and transmitting the novel coronavirus. Alberta Health Services require self-isolation for 14 days from the date a person has returned to Canada. ___________ (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 verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by Alberta Health, the Communicable Disease Control or any other governmental health agency. __________ (Initial)

OR

I verify that I am a healthcare/frontline worker who has worn appropriate PPE. ___________ (Initial)

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

____
SIGNATURE OF ADULT PATIENT (OR PARENT / ADULT GUARDIAN OF A CHILD)

____
Printed Name of parent/Adult Guardian of a Child

____
Date