COVID-19 Pandemic Dental Treatment Consent Form

Patient name: ____

CMOH Order 05-2020 legally obligates anyone with core symptoms of cough, fever, shortness of breath, runny nose, or sore throat (not related to pre-existing illness/condition) to quarantine for 10days from start of symptoms or until symptoms resolve, whichever is longer, or they have a negative COVID Test. People with symptoms should complete the COVID-19 Self-Assessment online tool to see if they should be tested.

■I understand the novel coronavirus causes the disease known as COVID-19, and this 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 other dental patients, characteristics of the virus, and nature of dental procedures, I have an elevated risk of contracting the virus simply by being in a dental office. ___________ (Initial)

■Patients **over 18**, I confirm I am **not** presenting any of the following core symptoms of COVID-19 identified by AHS:

- Fever > 38°C ___________ (Initial)
  Recorded Temperature:_______________________
- Cough ___________ (Initial)
- Sore throat ___________ (Initial)
- Shortness of breath ___________ (Initial)
- Runny Nose ___________ (Initial)

■Patients **under 18**, I confirm they are **not** presenting any of the following core symptoms of COVID-19 identified by AHS:

- Fever > 38°C ___________ (Initial)
  Recorded Temperature:_______________________
- Cough ___________ (Initial)
- Loss of sense of taste or smell ___________ (Initial)
- Shortness of breath ___________ (Initial)

■I know there are categories of people who are considered to be high risk. These factors are age 65+, heart/lung/kidney disease, diabetes or any auto-immune disorder. I am not high risk. ___________ (Initial)
OR I fall into the following high risk categories (________________________) and my dentist and I have discussed the risks, and I have agreed to proceed with treatment. ___________ (Initial)

■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. ___________ (Initial)

■I understand that if I must quarantine or have tested positive for COVID-19 I **cannot** enter a healthcare facility for 10 days or until my symptoms have resolved, whichever is longer. ___________ (Initial)

■I understand that travel from outside of Canada by any means greatly increases my risk of contracting/transmitting the novel coronavirus. AHS requires self-isolation for 14 days from the date a person returns to Canada. ___________ (Initial)

■I verify that I have **not** returned to Alberta from outside of Canada by any means in the past 14 days. ___________(Initial)

■I confirm that I am **not** a participant in the International Border Pilot Testing Program. _____________ (Initial)
OR I have participated in the International Border Testing Program and understand I am **not** permitted to enter a healthcare facility for 14 days after return from travel. _____________ (Initial)

■I understand that AHS asks individuals to keep physical distance >2 metres (6 feet) and it is **not** possible to maintain this distance when receiving dental treatment. ___________ (Initial)

■I have **not** been identified as a contact of someone who has tested positive for COVID-19 **or** been asked to self-isolate by AHS, 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 planned dental treatment completed today during the COVID-19 pandemic.

_________________________________ Printed Name:_________________________________ Date:_________________
SIGNATURE OF PATIENT