LAKESIDE DENTAL
of Mahogany

COVID-19 Pandemic Dental Treatment Consent Form

Patient name: _____

Parent/Guardian name (if applicable): _____

Date:_____

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 office. ____ (Initial)

My workplace is considered high-risk: Yes / No (Circle one)

If yes, please list location of workplace: _____

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)
- Recent loss of smell or taste ____ (Initial)

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

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

OR

I fall into the following high-risk category _____ (Name category) and my dentist and I have discussed the risks, and I agree to proceed with treatment. ____ (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 in for testing on their own volition as an asymptomatic individual does not need to indicate that.*

I verify that I have not returned to Alberta from any country outside of Canada whether by car, air, bus 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 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 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 worker who has worn appropriate PPE. _____ (Initial)

I understand that if I test positive for COVID-19 within 14 days of my last dental visit at Lakeside Dental of Mahogany, I must notify them immediately. ____ (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)

_____

Signature of Patient/Parent/Guardian