

## COVID-19 Pandemic Emergency Dental Treatment Consent Form

Patient Name: \_\_\_\_\_

Dentist: \_\_\_\_\_ Clinic: \_\_\_\_\_

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus.  
\_\_\_\_\_ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19:

- Fever > 37.5 C \_\_\_\_\_ (Initial)
- Shortness of Breath \_\_\_\_\_ (Initial)
- Cough \_\_\_\_\_ (Initial)
- Flu-like symptoms \_\_\_\_\_ (Initial)
- Sore Throat \_\_\_\_\_ (Initial)

I confirm that I am not currently positive for the novel coronavirus. I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. I verify that I have not returned to British Columbia 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. BC's Provincial Health Officer requires self-isolation for 14 days from the date a person has returned to Canada. \_\_\_\_\_ (Initial)

I understand that BC's Provincial Health Officer has asked individuals to maintain social 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 BC's Provincial Health Officer, the Communicable Disease Control or any other governmental health agency.  
\_\_\_\_\_ (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 emergency dental treatment completed during the COVID-19 pandemic.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date