M S GALIZA DENTAL CLINIC

COVID-19 Pandemic Dental Treatment Consent Form

Patient name: ____ Patient Age: ________________

Staff Screener: ____

Who answered: ◯ Patient ◯ Other (Specify) ____________________________

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.

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.

Screening questions

Do you have a fever of have felt hot or feverish anytime in the last 10 days? Temp taken at Appointment: 1)______ 2)______ Additional reading if temp. is > 38ºc: 3)______ 4)______ Chaperone's Temperature (When available): 1)______ 2)______	◯YES ◯ NO
Do you have any of these symptoms: New or worsening cough? New or worsening shortness of breath? Difficulty breathing? Sore throat or painful swallowing? Runny nose?	◯YES ◯ NO
Have you experienced a recent loss of smell or taste?	◯YES ◯ NO
Have you been in contact with any confirmed COVID-19 positive patients, person self-isolating because of a determined risk for COVID-19?	◯YES ◯ NO

(Healthcare workers who have worn appropriate PPE may answer "NO")	
Have you returned from travel outside of Canada in the last 14 days?	◯YES ◯ NO
Have you returned from travel outside of Canada from a location known affected with COVID-19 in the last 14 days?	◯YES ◯ NO
Is your workplace considered high risk? (Healthcare workers who have worn appropriate PPE may answer "NO")	◯YES ◯ NO

Patient Vulnerability

Are you over the age of 65?	**◯YES ◯ NO**
Do you have any of the following? Heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder? **If "YES" please indicate: ______________________________________**	**◯YES ◯ NO**

LIST of DENTAL TREATMENT (FOR DENTIST AND STAFF)

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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 or urgent dental treatment completed during the COVID-19 pandemic.

Patient Name (PRINT)___________________________________

SIGNATURE OF PATIENT ___________________________________

Parent / Guardian Name(PRINT) ____________________________

SIGNATURE OF PARENT / GUARDIAN ______________________

Date____

______________________ ____________

Dentist Dental Assistant