Patient Consent for Treatment During COVID-19 Pandemic

I _____ (patient name) understand that I am opting for an elective medical treatment/procedure/surgery.

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization and that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, social distancing is recommended. This is not entirely possible with my proposed treatment, however, I am satisfied that safety measures are in place to minimise risk as much as possible, and patient contact will be kept to an absolute minimum in line with medical need. _____ (initials)

I understand the Management and Clinical Staff are closely monitoring the COVID-19 situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective medical treatment/procedure/surgery, and I give my express permission to proceed. _____ (initials)

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I understand that COVID-19 can cause additional health risks, some of which may not currently be known at this time, in addition to those risks associated with the medical treatment/procedure/surgery itself. _____ (initials)

I have been given the option to defer my medical treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired medical treatment/procedure/surgery. _____ (initials)

I confirm that I am not presenting with any of the following symptoms of COVOID-19 listed below:

- Fever
- Shortness of Breath
- Loss of Sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat
- _____ (Initials)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. I confirm that I have not travelled in the past 14 days _____ (initials)

I confirm that if I develop COVID-19 symptoms following my medical treatment/procedure/surgery, or a known contact of mine develops symptoms, I will immediately inform the Aesthetic Skin Clinic to enable appropriate measures to be put in place and contact tracing to commence _____ (initials)

Patient name .....

Signature .....

Date .....

Clinician name .....

Signature .....

Date .....