COVID -19 INFORMED CONSENT

I _____(patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. _____ and all the staff at Physician Adventist Surgery Center are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However,

Given the nature of this Virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr._____ and staff at PASC to proceed with the same.

I understand that, even if I have been tested for COVID-19 and receive a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID19 after the test. I understand that, if I have a COVID19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: positive COVID-19 diagnosis, extended quarantine/self-isolation, additional test, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or hospital.

I understand that COVID19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risk described herein, as well as those risks described herein, as well as those risk for the treatment/procedure/surgery itself

I have been given the option to defer my treatment/surgery/procedure to a later date. However, I understand all the potential risks, including but not limited to the short-term and long-term complications related to COVID19, and I would like to proceed with my treatment/procedure/surgery.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE

_____

Patient or person authorized to sign Date/Time

_____

Witness Date/Time