Dr. TOM WIERZBICKI DDS FRCD(C)
PERIODONTICS & DENTAL IMPLANTS

<<Todays_Date>>

Patient COVID-19 Pandemic Dental Treatment Consent Form

Patient name: **<<Pat_FirstName>> <<Pat_LastName>>**

Chief Medical Officer of Health 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 dental procedures create water and/or blood spray which is one way that the novel coronavirus can spread. _____ **(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)**

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by Alberta Health Services:

Fever > 38°C	_____ **(Initial)**
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)**

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. I confirm that if I fall into the high risk category/categories I have discussed the risks with my dentist and I agreed to proceed with treatment. _____ **(Initial)**

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I confirm that I am not received a positive diagnosis for the novel coronavirus. In the last 14 days. _____ **(Initial)**

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus. _____ **(Initial)**

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 (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 Alberta Health, 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 dental treatment completed during the COVID-19 pandemic.

Patient Name: _____

Signature of Patient: _____

Date: _____