COVID-19 Pandemic Denture Treatment Consent Form

Patient name: _____

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 denturist patients, the characteristics of the novel coronavirus, and the characteristics of denture procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a denturist office. _____(Initial)

I confirm that I am **not** presenting any of the following symptoms of COVID-19 identified by BC Ministry of Health:

- Fever > 38°C
- Cough
- Sore Throat
- Shortness of breath
- Fatigue
- Diarrhea
- Muscle or body aches
- Headache
- Loss of taste or smell
- Congestion or runny nose
- Nausea or vomiting

_____ (Initial)

I confirm that I have considered if I am in a high-risk category (e.g. diabetes, heart disease, lung disease, over the age of 65, etc.) and I have chosen to seek denture treatment given the higher risk I may assume. _____ (Initial)

I confirm to the best of my knowledge I am not currently positive for the novel coronavirus. _____(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 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 and that BC Ministry of Health requires self-isolation for 14 days from the date a person has returned to Canada. _____ (Initial)

I understand that BC Ministry of Health 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 denture 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 Ministry of Health, the BC Centre for Disease Control or any other governmental health agency. _____(Initial)

LIST OF DENTURE TREATMENT REQUIRED:

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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 denture treatment completed during the COVID-19 pandemic. **(Please complete this on your treatment day only.)**

_____
SIGNATURE OF PATIENT

Printed Name_____ Date_____