



I _____ (or parent/guardian) understand that:

- The novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources.
- COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.
- I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic.
- Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) Initial Below

• I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted.

• I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that

I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time.

• I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____

• I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed here: *Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that in the past 14 days I have NOT travelled outside of The Republic of Ireland

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- I am informed that you have implemented preventative measures intended to reduce the spread of COVID-19.
 - However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you at your premises to proceed with providing care.
 - I understand that my contact details and name may be required by the Dept. of Health as part of their contact screening protocol.
 - I have been offered a copy of this consent form.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT DOCUMENT.

I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT.

BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE.

I GIVE MY PERMISSION FOR MY NAME AND CONTACT DETAILS TO BE GIVEN TO THE DEPT. OF HEALTH IF REQUIRED AS PART OF THEIR CONTACT TRACING OPERATION.

I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS HERE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE

SIGNED:

DATE: