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INFORMED CONSENT ABOUT COVID-19 RISK

Patient name:

Date of birth:

Address:

Clinic details:

I _____ (patient name) understand and accept the following. I have been given time to consider the information within this document and give my consent to undergo surgery considering the risks of COVID-19.

INITIALS:

_ I understand, from my surgeon and clinic, that I am undergoing an elective surgical procedure through my own choice.

_ I understand that COVID-19 is an infectious disease that has been declared a worldwide pandemic by the World Health Organisation and is associated with death in some people.

_ I understand there is a risk that I can catch COVID-19 before, during or after the time of surgery

_ If I suffer from COVID-19 I accept that it can be impossible to determine the contagious source of the disease

_ I understand that even if I have been tested for Coronavirus and received a negative test, the results in some cases fail to detect the virus. I also accept I can contract COVID-19 after a test has been performed.

_ I understand that if I suffer from COVID-19 after surgery, there might be a higher risk of death and suffering from the disease

_ I understand that contracting COVID-19 may result in the following; extended quarantine/self-isolation, additional tests, hospitalisation that may require medical therapy,

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intensive care therapy, intubation/ventilator support, increased complications for the treatment I am having, and other potential complications associated with COVID-19 treatment.

_ I understand that COVID-19 is a new disease and there may be additional risks that are currently unknown and that it is not possible to quantify the risk of complications right now.

_ I have been given the option to defer my treatment to a later date, I have been given the option to cancel my treatment and I would like to proceed with my desired treatment in full knowledge of the risks in this consent form.

_ I agree that if I develop symptoms, have contact with anyone or have been tested for coronavirus then I will inform my surgeon.

_ I agree that if I develop COVID-19 and suffer consequences there will be no financial compensation for COVID related complications or consequences

_ I agree that if I develop COVID-19 I will be treated within the NHS in an appropriate setting

Patient Signature:	Witness Signature:
Patient name: [PatientName]	Witness name:
Date: [TodayShort]	Date: [TodayShort]