COVID-19 Pandemic Emergency Dental Treatment Consent Form

London Heritage DENTAL

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 dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____ (Initial)

I have been made aware of the Royal College of Dental Surgeons of Ontario's guidelines that under the current pandemic all non-emergent dental care is not allowed. Dental visits should be limited to emergency dental treatment

- oral-facial trauma
- cellulitis or other significant infection, especially if compromising the patient's airway prolonged bleeding
- pain that cannot be managed by over-the-counter medications

OR urgent care, management and treatment of conditions that require immediate attention to relieve pain and/or risk of infection, including:

- severe dental pain from pulpal inflammation
- pericoronitis or third-molar pain
- surgical post-operative osteitis, dry socket dressing changes
- abscess or localized bacterial infection resulting in localized pain and swelling
  tooth fracture resulting in pain, pulp exposure or causing soft tissue trauma
- dental trauma with avulsion/luxation
- final crown/bridge cementation if the temporary restoration is lost, broken or causing gingival irritation
- biopsy of a suspicious oral lesion or abnormal oral tissue
- replacing a temporary filling in an endodontic access opening for patients experiencing pain
- snipping or adjusting an orthodontic wire or appliance piercing or ulcerating the oral mucosa
- treatment required before critical medical procedures can be provided

I confirm I am seeking treatment for a condition that meets these criteria. _____ (Initial)

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

- Fever > 38°C _____ (Initial)
- Cough _____ (Initial)
- Sore Throat _____ (Initial)
- Shortness of Breath _____ (Initial)
- Difficulty Breathing _____ (Initial)
- Flu-like symptoms _____ (Initial)
- Runny Nose _____ (Initial)

I confirm that I am not in a high risk category, including: diabetes, cardiovascular disease, hypertension, lung diseases including moderate to severe asthma, being immunocompromised, having active malignancy, or over age 65. _____ (Initial)

OR I fall into the following high risk category (_____) and my dentist and I have discussed the risks, and I agree to proceed with treatment. _____ (Initial)

I confirm that 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 Ontario 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. Public Health requires self-isolation for 14 days from the date a person has returned to Canada. _____ (Initial)

I understand that Public Health 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 Public 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 emergency dental treatment completed during the COVID-19 pandemic.

_____

SIGNATURE OF PATIENT

Printed Name_____ Date_____