NORA NUGENT
Aesthetic Surgeon

COVID-19 Risk Informed Consent Agreement

Name:
Date of birth:
Address:

I understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, government health agencies recommend social distancing.

Patient initials .....

I recognise that Ms Nora Nugent and all the staff at Aisling Plastic Surgery Ltd and Purity Bridge (hereinafter collectively "my Doctor") are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for my Doctor to proceed with the same.

Patient initials .....

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complications and death.

Patient initials .....

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalisation that may require medical therapy, intensive care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency department or a hospital.

Patient initials .....

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

Patient initials .....

I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my elective treatment/procedure/surgery.

Patient initials .....

I confirm neither I nor any individual living with me has any of the following COVID-19 symptoms; fever, shortness of breath, loss of taste or smell, dry cough, chest pain, runny nose, sore throat, neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. If I develop COVID-19 symptoms after my elective treatment/procedure/surgery, I will immediately inform my Doctor. I understand I must honestly disclose this information to avoid putting myself and others at risk.

Patient initials .....

I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realise that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission, I accept that the clinic/hospital will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

Patient initials .....

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

Patient initials .....

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TREATMENT/PROCEDURE/SURGERY. If I am the parent, legal guardian of the patient or hold power of attorney for health care for the patient, I have read this COVID-19 Informed Consent Agreement and am authorised to consent on the patient's behalf.

Signed: _____ **Date:** _____

Name: _____

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