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COVID-19 PANDEMIC INFORMED CONSENT

I 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 spread by person-to-person contact, and, as a result, federal and state health agencies recommend social distancing.

I recognize that my physician and all the staff at Randolph Health 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 treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment/procedure/surgery, and I give my express permission for my provider and all the staff at Randolph Health to proceed with the same.

I understand that even if I have been tested for COVID, a negative test result 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 treatment/procedure/surgery can lead to a higher chance of complication and death.

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
- hospitalization that may require medical therapy, intensive care treatment and possible need for intubation/ventilator support
- other potential complications
- risk of death.

In addition, after my treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

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.

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 / Designee Signature:_____ **Date:** _____ **Time:** _____

Printed Designee Name:_____ **Relationship:** _____

Witness Print Name:_____

Witness Signature:_____ **Date:** _____ **Time:** _____

Practitioner Print Name:

Practitioner Signature: **Date:** **Time:**