



## **COVID-19: Informed Consent**

I understand that I am consenting to a surgery that is not emergent.

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, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

**I understand that I am required to have a Covid-19 specimen collected and the result received within 96 hours maximum before my scheduled procedure and ensure a COVID-19 negative status. I understand that I must self-quarantine following testing and up until the day of surgery and I must social distance and wear a mask in my place of self quarantine.**

I understand that I must Immediately inform Eltra of any of the following:

- If I have any contact with a suspected or confirmed case of COVID-19
- If I have any contact with a person with symptoms consistent with COVID-19
- If I develop any symptoms consistent with COVID-19 while in self-quarantine

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection.

I understand that exposure to COVID-19 before, during, and after my surgery may result in a higher chance of complications and death. A positive COVID-19 diagnosis will result in extended isolation, possible hospitalization and need for treatment. After my surgery I may need additional care that may require that I go to an emergency department or hospital. I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the surgery.

I have been given the choice to have my surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_