COVID-19 Pandemic

Dental Treatment Screening and Consent Form

Clinic: White Rock Orthodontic Centre ☐ Whistler Orthodontic Centre ☐

White Rock and Whistler Orthodontic Centres are following all current COVID-19 guidelines established by the College of Dental Surgeons of British Columbia, the BC Centre for Disease Control and the BC Ministry of Health.

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus has a long incubation period during which carriers of the virus may not show symptoms and may still be contagious. I understand that although White Rock and Whistler Orthodontic Centres are doing all they can to minimize the risk to patients, they cannot eliminate the risk of transmission, and there remains a risk that staff or patients may be infected without knowing they are infected (i.e. an asymptomatic carrier). __________ (Initial)

I understand that dental procedures require physical proximity and touching, as well as create water, saliva and/or blood spray, which are some of the ways that the novel coronavirus can spread. In the case of spray, ultra-fine droplets can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. __________ (Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. ______________(Initial)

I confirm that I am <u>NOT</u> presenting any of the following symptoms of COVID-19, which according to guidance issued by the BC Centre for Disease Control, are similar to other respiratory illnesses such as the flu and common cold:

- Fever > 37°C ____________ (Initial)
- Chills ____________ (Initial)
- Cough ____________ (Initial)
- Sore throat / painful swallowing ____________ (Initial)
- Shortness of breath ____________ (Initial)
- Stuffy or runny nose ____________ (Initial)
- Loss of sense of smell ____________ (Initial)
- Muscle aches ____________ (Initial)
- Headache ____________ (Initial)
- Fatigue ____________ (Initial)
- Sneezing ____________ (Initial)
- Loss of appetite ____________ (Initial)

Patients considered high risk for severe COVID-19 include those with pre-existing conditions such as serious respiratory disease, serious heart conditions, immunocompromised conditions, severe obesity, diabetes, chronic kidney disease or those undergoing dialysis, and liver disease; pregnant patients; and patients who are 70 years and over. I confirm that I do not fall into any of these categories. ______________(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 understand that the BC Centre for Disease Control recommends, where possible, maintaining a physical distance of 2 metres from other people when outside the home, and that it is not possible to maintain this distance and receive dental or orthodontic treatment.____________ (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. BC's Provincial Health Officer requires self-isolation for 14 days from the date a person has returned to Canada. I confirm that I have not returned from outside Canada within the past 14 days.____________(Initial)

I verify that I have not been identified as a close contact of someone who has (i) tested positive for novel coronavirus, or (ii) a suspected case of novel coronavirus, nor have I been asked to self-isolate by BC's Provincial Health Officer, the Communicable Disease Control or any other government agency. ___________ (Initial)

LIST OF DENTAL TREATMENT

☐ Orthodontic Diagnosis and Treatment

CONFIRMATION OF CONSENT AND WAIVER

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above-listed dental treatment being performed during the COVID-19 pandemic, and I fully understand and acknowledge the risks to my health relating to COVID-19 transmission. I, for myself, my heirs, personal representatives or assigns, release and hold harmless White Rock and Whistler Orthodontic Centres and all related companies and partnerships, and all of their respective successors, administrators, directors, officers, employees, administrators, agents and assigns, from all claims of any kind relating to COVID-19.

SIGNATURE OF PATIENT (OR PARENT/GUARIDAN IF PATIENT IS A MINOR) ________________________________

Patient Name ____

Parent/Guardian Name ____________________________________

Date ____