



Oakville  
SLEEP DENTISTRY  
FOR KIDS & ADULTS

## COVID-19 Pandemic Treatment Consent Form

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 confirm I am seeking dental treatment at this time. \_\_\_\_\_ (Initial)

I confirm that my child is NOT presenting any of the following symptoms of COVID-19 identified by **Provincial** Health Services:

- Fever > 38°C \_\_\_\_\_ (Initial)
- Cough \_\_\_\_\_ (Initial)
- Sore Throat \_\_\_\_\_ (Initial)
- Shortness of Breath \_\_\_\_\_ (Initial)
- Flu-like symptoms \_\_\_\_\_ (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 **Provincial** Health Services has asked individuals to maintain social 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 **Provincial** Health, the Communicable Disease Control or any other governmental health agency. \_\_\_\_\_ (Initial)

Since your child will be receiving a General Anesthetic you have the option to select complete dental treatment under anesthesia today to prevent a second anesthetic for your child. Alternately, you can only have the area of concern addressed. This may necessitate a second general anesthetic for your child to complete the remaining treatment when it is safe to do so.

Please select which option you would prefer:

- Complete dental treatment under General Anesthesia \_\_\_\_\_

OR

- Specific dental treatment under General Anesthesia to address area of concern \_\_\_\_\_

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 / PARENT

Printed Name \_\_\_\_\_ Date \_\_\_\_\_