norwich cosmetic clinic
SKIN | FACE | BODY
6 Exchange Street Norwich, NR2 1AT

PATIENT CONSENT FOR TREATMENT DURING COVID-19 PANDEMIC

I_____ understand that I am opting for an elective medical treatment/procedure/surgery.

I understand that the novel Coronavirus, COVID-19, has been declared a worldwide pandemic by the Word Health Organisation and is believed to spread by person-to-person contact; and, as a result, social distancing is recommended. This is not entirely possible with my proposed treatment, however, I am satisfied that safety measures are in place to minimise risk as much as possible, and patient contact will be kept to an absolute minimum in the line with my medical treatment (____) – *Patient Initials*

I understand the Management and Clinical Staff are closely monitoring the COVID-19 situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. I understand there is inherent risk of becoming infected with COVID-19 by virtue of proceeding with treatment. I hereby acknowledge the risk of becoming infected with COVID-19 through this elective medical treatment/procedure/surgery, and I give my express permission to proceed (_____) – *Patient Initials*

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show any symptoms and still be highly contagious. I understand that COVID-19 can cause additional health risks; some of which may not currently be known at this time, in addition to those risks associated with the medical treatment/procedure/surgery itself. (_____) – *Patient Initials*

I have been given the option to defer my medical 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 that my follow up appointment can be postponed in case of further future lockdowns.
I can confirm that I am not presenting with any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Loss of sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat
- _____– *Patient Initials*

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. I confirm that I have not travelled in the past 14 days (_____) – *Patient Initials*

I confirm that if I develop COVID-19 symptoms following my medical treatment/procedure/surgery, or a known contact of mind develops symptoms, I will immediately inform the clinic to enable appropriate measures to be put in place and contact tracing to commence (_____) – *Patient Initials*

Patient Name…….

Signature……..
Date……..

Clinician Name……

Signature……
Date……