TAMARA R. FOUNTAIN, M.D

Ophthalmic Plastic and Reconstructive Surgery

Informed Consent for COVID-19

- I understand I am consenting to an elective treatment or procedure that is not urgent or 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 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, and that having the elective treatment/procedure/surgery can lead to a higher chance of complication and death.
- I understand that exposure to COVID-19 before, during, and after my treatment or procedure may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short- or long-term intubation, other complications, and death. After 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 elective procedure may put me at increased risk for becoming infected with COVID-19.
- I have been given the choice to have my treatment/procedure/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.
- By signing this consent form I accept that risk and give my permission to proceed with the treatment/procedure/surgery listed below.

Name of patient: _____

Patient date of birth: _____

Treatment/procedure/surgery: _____ _____

Signature:

Patient: _____

Date: _____