**Patient Consent for Treatment During COVID-19 Pandemic**

I (patient name) understand that I am opting for an elective medical treatment/procedure.

I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World health Organisation and that COVID-19 is extremely contagious 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 line with medical need. (Initials)

I understand the Management and Clinical staff are closely monitoring the COVID-19 situation and have put in place reasonable preventive measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective medical treatment/procedure, and I give my express permission to proceed. (Initials)

I understand the COVID-19 virus has as long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. I understand that C0VID-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 itself. (Initials)

I have been given the option to defer my medical treatment/procedure to a later date. However, I understand all the potential risks, including but not limited to the short term and long-term complications related to COVID-19, and I would like to proceed with my desired medical treatment/ procedure. (Initials)

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/ smell, dry cough, runny nose, sore throat. (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 (Initials)

I confirm that if I develop COVID-19 symptoms following my medical treatment/ procedure or a known contact of mine develops symptoms, I will immediately inform Bath Facial Aesthetics to enable appropriate measures to be put in place and contact tracing to commence. (Initials)

Patient Name Clinician Name

Signature Signature

Date Date