Dr. R. van Aardt
Cosmetic Medicine

RISK SCREENING & CONSENT

COVID-19 WELLNESS SCREENING CHECKLIST AND RISK CONSENT

Name: Date of Birth:

FOR YOUR SAFETY AND OURS this screening/risk consent questionnaire will be required to be completed virtually on a Patient Portal or Verbally over the phone or on site EVERYTIME within 48 hours upon arrival at our clinic.

Do you currently have any of the following symptoms?

__Y __N Severe Cough
__Y __N Headache
__Y __N Muscle Pains
__Y __N Significant Nasal congestion or significant runny nose
__Y __N Fever >38°C (Please provide actual measured temperature)
__Y __N Loss of sense of smell (Can you smell Peanut Butter if not loss of smell)

__Y __N Have you come into contact with anyone that has any of the above symptoms in the last two weeks?
__Y __N Have you come into contact with anyone suspected of having COVID-19 in the last two weeks?
__Y __N Have you failed to use social distancing in the last two weeks?
__Y __N Have you come into contact with anyone diagnosed with COVID-19 in the past two weeks?
__Y __N Have you been in contact with anyone that has traveled out of Province or Country in the past two weeks?

If you have answered YES to any of the above questions, you will NOT be able to have an appointment at this Clinic. You must see your Primary Care Physician or go to a COVID-19 Screening Clinic.

Please initial all and sign below:

____ I **understand** that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

____ I **also understand** that the novel corona virus, 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 provincial health agencies recommend social distancing. I recognize that any clinic operating under the name of Dr. Renier van Aardt Physician Incorporated and all the staff at these clinics are closely monitoring this situation and have put in place reasonable preventative measures aimed at reducing 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 this elective treatment/procedure/surgery.

____ I **understand** that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

____ I **acknowledge** that I have been given the option to defer my 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.

____ I **understand** that the staff reserve the right to change my appointment.

Clients **are advised to** arrive with no make-up, hair washed the morning of appointment and tied away from face.

BY SIGNING BELOW, I ACCEPT THE RISKS EXPLAINED ABOVE AND CONFIRM THAT I HAVE TRUTHFULLY ANSWERED THE SCREENING QUESTIONS.

_____	_____	_____
Print name of Client	Signature of Client	Date

Office use only:

__ NO to all questions. Patient allowed to book appointment and/or receive treatment.
__ All questions repeated and stated NO
__ Patient reminded that 48 hours prior to booked appointment this screening will be repeated.
__ Patient advised that additional screening will be done upon entering facility.
____°C - Hands free actual temperature taken upon entering.

_____	_____	_____
Print name of Screening Staff	Signature of Screening Staff	Date