

## Risk Assessment & Consent to Dental Appointment During COVID-19

Temperature of Patient on Arrival at the Practice: \_\_\_\_\_  
(This will be done by a team member when you arrive.)

I am aware that the current COVID-19 pandemic brings a number of known risks and a number of unknown risks. I have chosen to attend a dental appointment/undergo dental treatment during the pandemic in the knowledge that much is still unknown about the virus.

I understand the coronavirus that causes COVID-19 has a long incubation period during which time carriers of the virus may not show symptoms yet still be highly contagious. I also understand that some people may have the virus but may not ever have any symptoms. I therefore understand it is impossible to determine who has the virus and I understand that I must assume that anyone anywhere could be infected and infectious. \_\_\_\_\_ Initial by Patient

I confirm that **I am not currently suffering** from any of the below symptoms of Covid-19, and **I have not suffered** from any of these symptoms in the last 14 days.

- Fever (a temperature of 37.8 degrees centigrade or above).
- A new persistent dry cough.
- Muscle pains.
- Headache.
- Shortness of breath and breathing difficulties.
- Severe pneumonia.
- Loss of taste and/or smell.
- Extreme fatigue.
- Runny nose.
- Sore throat

\_\_\_\_\_ Initial by Patient

I confirm that to my knowledge **I have not been in close contact** (within 2 metres) of anyone suffering with any of the above symptoms in the last 14 days **OR** anyone who has tested positive for COVID-19 in the last 14 days. \_\_\_\_\_ Initial by Patient

**If you cannot confirm both of the above statements, you should phone the practice as soon as possible on 01489 572308, to cancel your appointment and reschedule.**

I understand that receiving dental treatment means that the UK government's instruction to maintain social distancing of at least 2 metres is **not achievable** during treatment.

\_\_\_\_\_ Initial by Patient

I understand that some people are considered to be at greater risk of serious illness or higher mortality if they contract COVID-19, and I understand that these are individuals who:

- Have pre-existing medical conditions such as heart and circulatory disease, respiratory disease, liver disease, kidney disease, or neurological disease.
- Have a weakened immune system.
- Have high blood pressure.
- Have diabetes.
- Have difficulties with their spleen.
- Are very overweight.
- Are male.
- Are over 60 years of age.
- Are from a black, Asian or minority ethnic (BAME) background.
- Are pregnant.

\_\_\_\_\_ Initial by Patient **& Please Circle Any of the Above That Apply to You**

I understand that Barker Dental Care will take precautions to make sure my appointment/treatment is provided according to strict clinical protocols and hygiene procedures.

\_\_\_\_\_ Initial by Patient

In order to comply with the FGDP guidelines to safeguard both our patients and staff, Barker Dental Care is required to purchase significant additional PPE and considerably more expensive PPE. Therefore, for an aerosol generating procedure (e.g. any treatment involving the use of a dental drill, ultrasonic, etc.), an additional charge will be applicable. \_\_\_\_\_ Initial by Patient

I consent to the dental appointment/treatment being provided during the current phase of Covid-19.

Patient Name: \_\_\_\_\_

1.) Date \_\_\_\_\_ Signature \_\_\_\_\_

2.) Date \_\_\_\_\_ Signature \_\_\_\_\_

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The below is to be completed by the Clinician-

**Aerosol Generating Treatment (AGP) OR Non-Aerosol Generating Procedure (non-AGP)**  
(Dentist/Hygienist Please Delete Above As Applicable)

I have reviewed the patient's completed risk/consent form.

Clinician Name: \_\_\_\_\_

1.) Date \_\_\_\_\_ Signature \_\_\_\_\_

2.) Date \_\_\_\_\_ Signature \_\_\_\_\_