

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

### UPDATED DECEMBER 2021

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

Please tick YES or NO to the questions below.

	YES	NO
1. Do you have any of the following symptoms: <ul style="list-style-type: none"> <li>• high temperature or fever?</li> <li>• New, continuous cough?</li> <li>• A loss or alteration to taste or smell?</li> <li>• Headache?</li> <li>• Runny Nose?</li> <li>• Fatigue?</li> <li>• Sneezing?</li> <li>• Sore Throat?</li> </ul>		
2. Have you or any member of your household/family had a confirmed diagnosis of COVID-19 in the last 10 days?		
3. Are you or any member of your household/family waiting for a COVID-19/SARS-CoV-2 PCR test result?		
4. Have you travelled internationally in the last 10 days to a country that is on the government red list?		
5. Have you or any member of your household/family been advised to isolate by any NHS organisation in the last 10 days?		

**If you answer YES to any 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

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

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

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

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

3.) Date \_\_\_\_\_ Signature \_\_\_\_\_

\_\_\_\_\_ The below is to be completed by the Clinician-

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

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

**CIRCLE AS APPROPRIATE**

1.) Date \_\_\_\_\_ Signature \_\_\_\_\_ AGP / Non-AGP

2.) Date \_\_\_\_\_ Signature \_\_\_\_\_ AGP / Non-AGP

3.) Date \_\_\_\_\_ Signature \_\_\_\_\_ AGP / Non-AGP