Required Forms

# PATIENT EVALUATION& LIABILITY FORMS

Please print, sign and bring to your appointment

*These documents are for reference purposes only. It is intended to provide general guidance, is not legal advice and is not a statement regarding any standard of care. This document does not reflect every law or requirement of federal, state or local authorities which may be applicable to you or your practice site(s)*

# Covid-19 Patient Information

Covid19 Patient Questionnaire and Release Forms

EuroThreads LLC

# Covid-19 Medical Assessment Form

Name: _____

Date of Birth: _____

Type of Procedure: _____ Date of Procedure: _____

## HISTORY

Have you or anyone in your household been diagnosed with Covid-19? ❒Yes ❒No

Have you or anyone in your household been within 15 feet of a person with a lab diagnosed case of Covid-19 for at least 5 minutes? ❒Yes ❒No

Have you or anyone in your household traveled outside of the country in the last 30 days? ❒Yes ❒No

Have you or anyone in your household traveled to any areas deemed to have a high concentration of confirmed Covid-19 cases in the last 30 days? ❒Yes ❒No

Have you or anyone in your household had exposure to any "Person(s) Under Investigation" (PUI) for Covid-19? ❒Yes ❒No

Have you or anyone in your household traveled to, reside and or work in local areas that have reported Covid-19 cases? ❒Yes ❒No

Review of Symptoms: *(please check all that apply in the past 14 days)* ❒ Fever / Fever like Symptoms

❒ Shortness of breath or severe wheezing ❒ Muscle Aches ❒ Headache ❒ Decrease in your ability to Taste or Smell ❒ Fatigue or Loss of Energy ❒ Stomach Issues ❒ None of the Above

Patient Signature: _____ Print: _____ Date:_____

## PHYSICAL EXAMINATION *To be confirmed by provider on site. Check all that apply*

❒ Fever of 100.5 or higher ❒ Dry Cough ❒ Flu Like Symptoms
❒ Sore Throat ❒ Difficulty Breathing ❒ Headache

Additional Findings:

_____

Provider Signature: _____ Print: _____ Date:_____

# Precautionary Coronavirus Liability Release Form

Due to the 2019-2020 outbreak of the novel Coronavirus, COVID-19, we are taking extra precautions with the intake of each client, health history review, as well as sanitation and disinfecting practices. Please complete the following and sign below.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry cough
- Difficulty breathing

I, _____ agree to the following:

I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above within the last 14 days.

I affirm that I, as well as all household members, have not been diagnosed with COVID19 within the last 30 days.

I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 within the last 30 days.

I affirm that I, as well as all household members, have not traveled outside of the country, or to any city outside of our own that is or has been considered a "hot spot" for COVID-19 infections within the last 30 days.

I understand that this business and my injector cannot be held liable for any exposure to the virus or any other contagion caused by misinformation on this form or the health history provided by each client.

By signing below I agree to each of the above statements and release the provider, the staff and business _____ (practice name) from any and all liability for the unintentional exposure or harm due to COVID-19.

Your provider and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly fight the spread of COVID-19 and other communicable conditions.

I UNDERSTAND THE INFORMATION ENCLOSED, HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

**Patient or Person Authorized to sign for Patient**

Signature:_____Date:_____

**Witness**

Signature:_____Date:_____

**COVID-19 RISK INFORMED CONSENT**

I _____ (patient name) 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 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 recognize that Dr. Steve Sample and all the staff at _____ (practice name) and _____ (facility name) are closely monitoring this situation and have put in place reasonable preventative 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 this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. Steve Sample and all the staff at _____ (practice name) and _____ (facility name) to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

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 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 THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

**Patient or Person Authorized to Sign for Patient**

_____Date/Time_____

**Witness**

_____Date/Time_____

I have been offered a copy of this consent form (patient's initials) _____