

COVID-19 RISK INFORMED CONSENT

I \_\_\_\_\_ (patient name) understand that I am opting for an elective procedure 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 is extremely contagious, and as a result, health agencies recommend wearing masks and social distancing. I recognize that Dr. Baxter and all the staff at Baxter Plastic Surgery have put in place reasonable preventative measures aimed to reduce the spread of COVID. 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 through this elective procedure, and I give my express permission for Dr. Baxter and all the staff at Baxter Plastic Surgery 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 infection, and even if I do not have any symptoms, proceeding with this elective procedure can lead to a higher chance of complication and death. I consent to pre-operative testing for COVID and understand that a positive test will require postponement of my surgery, treatment, or procedure.

I understand that possible exposure to COVID before/during/after my procedure may result in the following: a positive COVID 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 procedure, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID may cause additional risks, some of which may not be known at this time, in addition to the risks described herein, as well as those risks for the procedure itself. I have been given the option to defer my procedure 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, and I would like to proceed with my desired procedure.

I UNDERSTAND AND ACCEPT THESE CONDITIONS AND CONSENT TO THE PROCEDURE.

Patient signature \_\_\_\_\_ Date/Time \_\_\_\_\_

Witness name/signature \_\_\_\_\_ Date/Time \_\_\_\_\_

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