DR BRIAN BUINEWICZ
plastic surgery + wellmed spa

COVID-19 RISK INFORMED CONSENT

I _____ (print patient name) understand that I am opting to undergo an elective treatment/procedure/surgery.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. 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 my surgeon/physician and the staff at Abington Surgical Center 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. Accordingly, I acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery and consent for my surgeon/physician and the staff at Abington Surgical Center to proceed with the treatment/procedure/surgery.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I am asymptomatic, 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 generally associated with 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 agree to assume these risks. I would like to proceed with my desired treatment/procedure/surgery and do not wish to defer it.

I understand this is a special consent for an elective treatment/procedure/surgery during the COVID-19 pandemic. This special consent is only being used because of the unique circumstances surrounding the pandemic.

By signing this document, I certify that I have read it, that I have had an opportunity to ask any questions I have about this document, that I understand it, that I have signed it knowingly and voluntarily, that I am the above-named patient, or a parent, guardian or representative authorized to execute this document on behalf of the patient, and that I accept and intend to be legally bound by its terms.

_____ _____
Patient's Signature Date

IF PATIENT IS A MINOR OR UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is unable to sign
because_____
__

_____ _____
Parent/Guardian/Responsible Party Date

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