**The St. Peters Dental Practice**

**32 High Street, St. Peters, Broadstairs, Kent, CT10 2TQ**

**Consent to dental treatment during COVID-19**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I consent to having my Temperature taken. My Temperature today is:**

**Initial**

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| --- | --- |
| I am aware the current COVID-19 pandemic brings a number of risks and a number of unknown risks. I have chosen to seek dental treatment during the pandemic in the knowledge that much is still unknown about the SARS -COV- 2 virus that causes COVID-19.  I understand the SARS-COV-2 virus has long incubation period during which carriers may not show symptoms yet are still potentially highly contagious. I also understand that some people may have the virus and may never show any symptoms. I therefore understand it is impossible to determine who has the virus and I must assume that anyone anywhere could be infected and therefore infectious.    I have been made aware that during the current phase of the pandemic dental care has been limited to avoid face to face contact.  I have been made aware that urgent dental care especially on symptomatic or tested positive individuals has been designated to the NHS UDC hubs.  I confirm that I wish to be treated at the St. Peters Dental Practice and Dr Gordon has agreed to provide the treatment I require.  I confirm I understand the risks and benefits of the treatment proposed as explained to me.  All my questions have been answered to my satisfaction.  I confirm I am not currently suffering and have not suffered from any of the following symptoms that have been associated with COVID-19 within the past  7 days  i) Fever with Temperature greater than 37.8 degrees Celsius  ii) Persistent dry cough  iii) Muscle pains  iv) Headache  v) Pneumonia  vi) Shortness or breathe or breathing difficulty  vii) Loss or taste and/or smell  viii) Extreme fatigue  ix) Runny nose  x) Sore throat |  |
| I confirm I have not been in close contact (within 2 metres) of anyone suffering from any of these symptoms within the past 14 days.  I understand that receiving dental treatment requires physical contact and encroachment on the recommended 2 metre physical distancing and I am satisfied that this is necessary.  I understand that Dr Gordon has taken every precaution to ensure the treatment is provided safely and I consent to the treatment being provided during this current phase of the COVID-19 pandemic. |  |

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_