

Name:

Address:

Hospital Number:

DoB:

COVID-19 Specific Consent Form

General

* The alternatives to the procedure I am attending for have been discussed with me, as have the risks of not proceeding with the procedure which could include a worse outcome from the underlying disease
* I have been warned that attending hospital might increase my risk of catching COVID-19
* I have been warned that if I do catch COVID-19, it may make my recovery from my procedure more difficult, it may increase my risk of serious illness or even death
* I have been warned that if I need critical care during my stay I might be moved to another hospital
* It has been explained that it is likely that I will not be able to have friends and family visit me whilst in hospital.

Specific

* I have not experienced any COVID-19 symptoms during the self-isolation period.
* I confirm that I have been self-isolating for the number of days requested by my hospital.
* No members of my household or other contacts have been unwell with COVID-19 symptoms during the self-isolation period.
* I have undergone COVID-19 swab testing and understand that I have tested negative for COVID-19.

**Patient**

Signature ………………………………………………..

Name (PRINT) ………………………………………….. Date ……………………

**Clinician**

Signature …………………………………………………

Name (PRINT) …………………………………......... Date …………………………….