MDA Medical Aesthetics Inc. COVID -19 QUESTIONNAIRE

In order for us to perform your treatment please answer questions, sign & date the consent.

1. Have you traveled within the last 14 days or come into close contact with anyone who has traveled?
   Yes _____ **No** _____

2. Have you been diagnosed with COVID-19 in the last 14 days or come into close contact with anyone who has been diagnosed with COVID-19?
   Yes _____ **No** _____

3. Have you or anyone you have come into close contact with experienced any of the following symptoms within the last 14 days? fever, chills, shortness of breath, cough, loss of taste or smell, sore throat, difficulty breathing, chest pain, confusion, runny nose, pink eye, congestion, headache, digestive issues, unusual fatigue, muscle aches
   Yes _____ **No** _____

4. Are you aged 70 or over? **Yes** _____ **No** _____

5. Have you visited a hospital or other health care facility for treatment in the last 14 days?
   Yes _____ **No** _____

6. Do you have a chronic health condition, an autoimmune condition or other immune compromise? **Yes** _____ **No** _____

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/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-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and provincial health agencies recommend social distancing. I recognize that all the staff at **MDA Medical Aesthetics Inc.** clinic 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. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure, and I give my express permission for **MDA Medical Aesthetics Inc.** clinic and all the staff and to proceed with the same.

MDA Medical Aesthetics Inc. Risk Informed Covid-19 Consent (continued)

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 can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure 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/ itself. 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.

Date:_____

Signature:_____

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