

Emergency Endodontic Treatment During Covid-19 Pandemic

I, _____, knowingly and willingly consent to have emergency Endodontic treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing. Endodontic procedures have the potential of creating water spray which can lead to the transmission of the disease. The aerosol droplets from the water spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus. Endodontic procedures use a rubber dam isolation method to treat teeth; this isolation method greatly reduces the aerosol spray. We are doing everything in our power to minimize this transmission with a negative pressure room. We also are going to minimize other sources of aerosol as much as possible. However, even with these measures, there is no guarantee that you will not be infected with COVID-19.

I understand that due to the frequency of visits of other endodontic patients, the characteristics of the virus, and the characteristics of the endodontic procedures, that I have an elevated risk of contracting the virus simply by being in an endodontic office. _____ (Initial)

I have been made aware of the CDC, Pennsylvania Department of Health, and ADA guidelines that under the current pandemic, only emergent endodontic care is recommended. Endodontic visits should be limited to the treatment of pain, infection, oral and facial trauma, and other conditions that may threaten the health of the patient. Conditions that endanger the patient with respect to possible hospitalization or a significant facial infection (cellulitis) are of the utmost importance. Please note that we are doing our best to minimize your treatment during this time but also prevent a serious infection. _____ (Initial)

I confirm that I am seeking treatment for a condition that meets these criteria. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below: _____ (Initial)

- Fever
- Shortness of breath
- Dry cough
- Runny nose
- Sore throat
- Body aches
- Diarrhea
- Lack of taste
- Lack of smell

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. In addition, the CDC recommends social distancing of at least 6-feet for a period of

14 days to anyone who has traveled by air. I recognize that this social distancing is not possible with endodontic treatment. _____ (Initial)

I verify that I have not traveled outside the United States in the past 30 days to countries that have been affected by COVID-19. _____ (Initial)

I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 30 days. _____ (Initial)

I verify that I have not been to the areas with a significant amount of COVID-19 infection such as New York, Washington, California, New Jersey, Massachusetts, Florida, or any other area with a high rate of infection within the past 30 days. _____ (Initial)

I verify that I have not been in contact with any known positive COVID—19 patients.
_____ (Initial)

I verify that I have not been in contact with anyone currently under home isolation or quarantine.
_____ (Initial)

I verify that I have not been in contact with anybody with symptoms as noted above including fever, shortness of breath, dry cough, runny nose, sore throat, body aches, diarrhea, lack of taste, and lack of smell. _____ (Initial)

I verify that if I develop any of these symptoms or if I test positive to COVID-19 in the future, I will notify your office immediately. _____ (Initial)

Patient/Guardian

Signature: _____ Date: _____

Emergency Treatment Release

I, _____, will hold harmless and indemnify, the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions, in exchange for oral surgical treatment during a COVID-19 National Emergency.

You are receiving endodontic care during a COVID-19 National Emergency. Please be advised that there may be risks in being in the proximity of Endodontists, patients, and staff. We are taking every precaution possible to limit the spread of the disease, yet there is still a possibility of transmission.

Acknowledgement

I, _____, make this decision of my own free will relying upon my knowledge and judgment of any injury I may have sustained or possible transmission of COVID-19 during treatment. My decision to release has not been affected by any false statements or representations pertaining to these possible injuries including the possible infection with the COVID-19 virus. I understand that this decision to release represents a compromise between myself as the patient and the doctor. Accordingly, this agreement is not an admission of any liability regarding the doctor, practice, associates, employees, successors, assigns, legal representatives, organizers, sponsors, and supervisors, against any claims, and actions. I have carefully read this release and understand its contents, and I am signing it of my own free act.

Patient/Guardian

Signature: _____ Date: _____

Treating Doctor

Signature: _____ Date: _____

Corona Virus Questionnaire

Please let us know if you have tested positive for the Corona Virus? Yes No

Have been tested for the Corona Virus but do not yet have the results? Yes No

Have recently (within the past six weeks) traveled to an area known to have a high prevalence of COVID-19? Yes No

Areas with high prevalence of COVID-19:

International - China, Italy, Iran, Spain, Germany, South Korea, France

Within U.S. – New York, Washington, California, New Jersey, Massachusetts, Florida, Eastern Pennsylvania (Allegheny County), Ohio, Louisiana

Have you had contact with any known positive COVID-19 patients? Yes No

Have you had contact with anyone currently under home isolation or quarantine? Yes No

Have you had contact with any people with concerning symptoms? Yes No

Are you having any of the following symptoms?

Fever or temperature greater than 99.5	Yes	No
Cough	Yes	No
Difficulty breathing	Yes	No
Body aches	Yes	No
Any flu-like symptoms	Yes	No
Lack of taste	Yes	No
Lack of smell	Yes	No
GI symptoms such as diarrhea	Yes	No

Also remember to: Wash hands frequently.

Use hand sanitizer often.

Sneeze and cough into your sleeve, not your hands.

Use social distancing (six feet apart when possible).

Elbow bump or wave instead of shaking hands.

Please help to minimize the spread of the corona virus and the flu by following these simple steps.

