Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

COVID-19 Risk Informed Consent

I_________________________________(patient name) understand that I am opting for an elective procedure.

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 state health agencies recommend social distancing. I recognize that physicians and staff at Northwest Gastroenterology Clinic and NGC Endoscopy Services 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 procedure. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this procedure, and I give my express permission for Dr. ____________________________ and all the staff of Northwest Gastroenterology Clinic and NGC Endoscopy Services to proceed with the same.

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 procedure can lead to a higher chance of complication and death.

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

I have been given the option to defer my procedure 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 I would like to proceed with my desired procedure.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient or Person Authorized to Sign for Patient ______________________________ Date/Time ______________________________

Witness______________________________ Date/Time______________________________