COASTAL VIRGINIA
SURGERY CENTER

Surgery Consent during COVID-19

_____ Initial

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The disease causes respiratory illness (like the flu) with symptoms such as a cough, fever, and in more severe cases, difficulty breathing. COVID-19 is spread through close personal contact or airborne droplets - coughing or sneezing. People may also contact the illness if they touch a surface infected with COVID-19 and then touch their mouths, noses or eyes. There's currently no vaccine to prevent COVID-19.

_____ Initial

I understand that my physician has determined that my planned procedure/surgery is medically necessary and permissible.

_____ Initial

I understand that although proper interventions are in place to minimize the risk of COVID-19 transmission, the ability to completely remove the risk to me is not possible. I understand that it is my choice to have the procedure/surgery now, or wait until a later time.

_____ Initial

By consenting to this procedure/surgery, I acknowledge the possible risk of COVID-19 transmission to me.

_____ Initial

In the event that I developed any surgical complications or post-surgical complications, I understand that I may have to be transferred to a hospital for care. If I need to be admitted to a hospital, I could potentially be exposed to patients with COVID-19.

_____ Initial

I have discussed with my physician the risks of proceeding with the procedure/surgery and with delaying the procedure/surgery. I have decided to proceed with the procedure/surgery. I understand that I accept full responsibility for any consequences of that decision.

I acknowledge that I have read this document in its entirety and that I fully understand it prior to signing. I understand that I am to make inquiries regarding any aspect of my/the patient's diagnosis or treatment which I do not understand. I represent to my/the patient's physician and The Coastal Virginia Surgery Center that I am eligible to give this consent.

Patient Signature: _____ Date/Time: _____

Legal Representative Signature: _____ Date/Time: _____

Printed Name: _____ Relationship: _____

Witness: _____ Date/Time: _____