

☐ I understand that I am opting for an elective medical treatment/procedure/surgery.

☐ I understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization and that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, social distancing is recommended. This is not entirely possible with my proposed treatment, however, I am satisfied that safety measures are in place to minimise risk as much as possible, and patient contact will be kept to an absolute minimum in line with medical need.

☐ I understand the Management and Clinical Staff are closely monitoring the COVID-19 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 treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective medical treatment/procedure/surgery, and I give my express permission to proceed.

☐ 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. I understand that COVID-19 can cause additional health risks, some of which may not currently be known at this time, in addition to those risks associated with the medical treatment/procedure/surgery itself.

☐ I have been given the option to defer my medical treatment/procedure/surgery 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 medical treatment/procedure/surgery.

☐ I confirm that I am not presenting with any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Loss of Sense of Taste or Smell
- Dry Cough
- Runny Nose
- Sore Throat

☐ I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. I confirm that I have not travelled in the past 14 days.

☐ I confirm that if I develop COVID-19 symptoms following my medical treatment/procedure/surgery, or a known contact of mine develops symptoms, I will immediately inform Bella You to enable appropriate measures to be put in place and contact tracing to commence.

PRINT NAME (PATIENT)	PRINT NAME (CLINICIAN)
SIGNED (PATIENT)	SIGNED (CLINICIAN)
DATE	DATE