Dr. Gregory A. Greco
Plastic, Cosmetic & Reconstructive Surgery

NJSPS
NEW JERSEY SOCIETY OF PLASTIC SURGEONS

NJSPS COVID-19 Risk Informed Consent Form

(Revised 5/10/2020)

I _____ **(patient name)** understand that I am opting for an elective treatment/procedure/surgery that is not urgent.

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 **Dr. Gregory A. Greco** and all the staff at **Monmouth Plastic Surgery, Monmouth Medical Center and Shrewsbury Ambulatory Surgery Center** are closely monitoring the 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/surgery.

I understand that even with **Monmouth Medical Center and Shrewsbury Ambulatory Surgery Center** following all the CDC guidelines for infection control of COVID-19 in providing emergency treatments, that I am still at risk for a possible infection with receiving such treatment at **Monmouth Medical Center and Shrewsbury Ambulatory Surgery Center** at this time. _____**(initial)**

I understand that the procedures may include aerosol-generating procedures as well as anticipated splashes and sprays, which are some of the ways that COVID-19 can be spread. _____**(initial)**.

I also understand having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. The virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary. _____**(initial)**

I hereby acknowledge and assume the risk of becoming infected with the COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for **Dr. Gregory A. Greco** and all the staff at **Monmouth Plastic Surgery, Monmouth**

Medical Center and Shrewsbury Ambulatory Surgery Center to proceed with the same. _____**(initial).**

I understand if the symptoms listed below are representative of COVID-19:

- Fever
- Dry cough
- Shortness of breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face •Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell

In addition, a list of the most up-to-date symptoms related to COVID-19, may be found by referring to the following link: www.cdc.gov/coronavirus/2019- ncov/ symptomstesting/symptoms.html

I confirm that I, and those who live with me, have not displayed, or currently have, any of the symptoms that are representative of COVID-19, which are outlined above._____**(initial)**

I confirm that, to the best of my knowledge, in the past 14 days I have not come into close contact with anyone who appeared to me as displaying, or having, any of the symptoms that are representative of COVID-19, which are outlined above._____**(initial)**

I confirm, to the best of my knowledge, that I have not had close contact with an individual diagnosed with COVID-19 in the past 14 days._____**(initial)**

I understand that all travelers arriving from a country, region with widespread ongoing transmissions should stay home for 14 days to practice social distancing and monitor their health after their arrival.

I confirm that I, and those who live with me, have not returned in the past 14 days from traveling to any of the countries or regions with widespread ongoing transmission, including all European countries, China, Korea, and Latin America._____**(initial)**

For a list of the most up-to-date travel considerations related to COVID-19, may be found by referring to the following link: www.cdc.gov/coronavirus/2019- ncov/ travelers/index.html

I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure._____**(initial)**

I understand it if I test negative for COVID-19, I must self-isolate at home until I have my procedure to avoid possible exposure to COVID19 in the community._____**(initial)**

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 a virus or I may have contracted COVID after the test. I understand that, if I have a COVID19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/ procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/ procedure/surgery may result in the following: a positive COVID-19 diagnosis, 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/surgery itself.

Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the option to defer my 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 treatment/procedure/surgery._____ (initial)

I acknowledge that I have read and understand this Release and that I knowingly and voluntarily have signed this consent agreeing to be treated by _____(Doctor's name) and the_____(facility name).

Patient Name:_____
(Print)

Patient/Guardian signature:_____

Date:_____

Witness:_____

Name:_____
(Print)

Signature:_____

Date:_____

For Practice use:

Doctor Signature:_____**Date:**_____