Driftwood Dental
Committed to Dental Excellence

To be completed by RN/CDA for both patient and ride

COVID-19 Risk Assessment Form

Date: _____ PtName: _____

Ride Name/#: _____

Procedure: _____ Occupation: _____

Guardian Occupation _____

Phone Screening:

Fever?	Y / N	Difficulty Breathing?	Y / N
Chills?	Y / N	Shortness of breath?	Y / N
Loss of Smell?	Y / N	Dry Cough?	Y / N
Sneezing?	Y / N	Runny Nose?	Y / N
Post Nasal Drip?	Y / N	Sore Throat?	Y / N
Loss of Appetite?	Y / N	Muscle aches?	Y / N
Nausea/Vomiting/Diarrhea?	Y / N	Headaches?	Y / N
Test Positive?	Y / N	Fatigue?	Y / N
Contact with Pos Case?	Y / N		
Live/Work in Outbreak?	Y / N		

Attend lg events (50+)? Y / N If so, when/where? _____

Travel? US? Intl? - Self Iso? Y / N If so, when/where? _____

Advised to self Isolate? Y / N If so, when/where? _____

IF YES TO ANY OF THE ABOVE QUESTIONS (IF NO SEASONAL ALLERGIES) IN-CLINIC TREATMENT MUST BE REFERRED TO HOSPITAL SETTING

Seasonal Allergies? Y / N Allergies: _____

Medical Allergies? Y / N Allergies: _____

IF ELIGIBLE FOR IN-CLINIC TREATMENT

Reconfirm:		Pre-rinse Rinse?	Y / N
Phone Screening?	Y / N	Hand Sanitizer/Washing?	Y / N
Covid Test?	Y / N N / P	Consent forms?	Y / N
Temp reading:	_____	Pulse Oximeter	_____

Consent Form During Pandemic

The best available scientific evidence is that COVID-19 is transmitted through the release of droplets into the air onto surfaces, including by sneezing or coughing. We encourage all patients who have questions about the safety of dentistry during COVID19 to address them with their dental care provider. Certain dental procedures create water spray which may contribute to the risk of transmission. At this time, dental practices will attempt to limit treatment to procedures that do not produce spray (aerosol) whenever possible. This may mean that a temporary solution or modified treatment approach may be required. Sometimes it is not possible to eliminate aerosols.

While much about COVID19 still remains unknown, there may be a risk of contracting the virus in a dental office.

The following dental treatment is recommended forme: _____

_____

_____

_____

_____

Acknowledgement and Consent

- I have received information about COVID-19 .
- I acknowledge that I have informed the dental practice if I have ANY of these symptoms or risk factors.
- I accept the risks of transmission of the virus in a dental office setting.
- I understand that the dental treatment options may be limited during this time in an effort to reduce/eliminate the risk of transmission.
- I have had the above treatment explained to me, including the risks and benefits, treatment alternatives, cost, follow-up requirements, and consequences of no treatment.
- I have had an opportunity to ask questions and have had my questions answered to my satisfaction.
- I consent to and wish to proceed with above dental treatment.

Patient Signature: _____

Printed Name:_____ Date: _____