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SASREG

Southern African Society for Reproductive Medicine and Gynaecological Endoscopy

COVID-19 PANDEMIC – DISCLOSURE AND CONSENT FORM

I ....

(**Full name of patient**)

RESIDING AT

....
....
....

1. I knowingly and willingly consent to have elective or emergency medical treatment during the COVID-19 pandemic.

2. I understand that:
   - People can catch COVID-19 from others who have the virus.
   - The disease can spread from person to person through small droplets from the nose or mouth which are spread when a person with COVID-19 coughs or exhales.
   - These droplets land on objects and surfaces around the person.
   - Other people then catch COVID-19 by touching these objects or surfaces, then touching their eyes, nose or mouth.
   - People can also catch COVID-19 if they breathe in droplets from a person with COVID-19 who coughs out or exhales droplets. This is why it is important to stay more than 1,5 meters away, especially from a person who is sick.
   - The COVID-19 virus has an incubation period during which carriers of the virus might not show symptoms and still be highly contagious.

3. I understand that medical procedures may take place with the patient in close proximity to the medical practitioner. This potentially exposes the patient and the medical practitioner to respiratory droplets which may spread the disease.

4. I understand that due to the frequency of visits of other patients, the characteristics of the virus, and the nature of consultations and medical procedures, that I have an elevated risk of obtaining the virus simply by being in a medical practice.

5. I understand that I will need to wear a mask that covers mouth and nose when I visit the clinic. I understand that I will not be allowed in the medical practice without a mask.

6. I understand that I will undergo a COVID-19 test a few days before any assisted reproductive procedure. I understand that if the COVID-19 test is positive, the assisted reproductive procedure will be cancelled. I will be liable for the costs incurred until the moment of the cancellation.

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7. I confirm that I am not presenting with any of the following symptoms of COVID-19 listed below and that I will inform the medical practitioner immediately should I develop these symptoms. I understand that if I develop COVID-19 symptoms, the assisted reproductive procedure will be cancelled. I will be liable for the costs incurred until the moment of the cancellation.
   - Fever
   - Shortness of breath
   - Sore throat
   - Cough
   - Tiredness

8. I understand that the effects of COVID-19 on pregnancy including maternal and foetal risks are still largely unknown.

9. I understand that this disclosure and consent form needs to be completed, signed and a copy thereof sent to the medical practice at least one day before my scheduled appointment. I also understand that I need to bring along some form of identification, that will be shown to the personnel at the practice upon my arrival.

SIGNED AT...

THIS...DAY OF...20........

Patient: ....

For official use only:

Witness signature: ________________ Witness name: ____________________
(to be signed by practice personnel after positive confirmation of identification)

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