RW AESTHETICS

CLIENT NAME*

DATE*

NB: *Dr Worrall is currently a doctor at Royal Shrewsbury Hospital. As with all keyworkers, CVOID-19 tests are frequent and safety procedures of the highest standards but due to the nature of hospital work you need to be aware of this.*

I (client) understand that I am opting for an elective treatment/procedure that is not urgent and may not be medically necessary.

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

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

PLEASE INITIAL*

I declare that I have not tested POSITIVE for COVID-19 and have not been exposed to anyone in my household or workplace that has had any of the above symptoms or tested POSITIVE in the past 14 days.

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PLEASE INITIAL*

I declare that I am not considered vulnerable, shielding nor self-isolating.

PLEASE INITIAL*

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.

PLEASE INITIAL*

I understand that COVID-19, has been declared a worldwide pandemic by the World Health Organisation and that it 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 aesthetic treatments, however, I am satisfied that safety measures are in place to minimise risk as much as possible, and that client contact will be kept to an absolute minimum in line with the medical need.

PLEASE INITIAL*

I understand that the management are closely monitoring the COVID-19 situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. 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.

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PLEASE INITIAL*

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.

PLEASE INITIAL*

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test.

PLEASE INITIAL*

I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure, and I give my express permission to Dr Rhiannon Worrall and RW Aesthetics Shropshire to proceed.

PLEASE INITIAL *

I understand that if I have a COVID-19 infection, and even if I do not have any symptoms, proceeding with this elective treatment can lead to a higher chance of complications, illness or worse.

RW AESTHETICS

PLEASE INITIAL*

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 itself.

PLEASE INITIAL*

I have been given the option to defer my treatment 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.

PLEASE INITIAL*

CLIENT SIGNATURE*

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.