Addendum to Surgery & Anesthesia Consent during COVID-19 Pandemic

_____ Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The disease causes respiratory illness (like the flu) with symptoms such as a cough, fever, and in more severe cases, difficulty breathing. COVID-19 is spread through close personal contact or airborne droplets – coughing or sneezing. People may also contact the illness if they touch a surface infected with COVID-19 and then touch their mouths, noses or eyes. There's currently no vaccine to prevent COVID-19.

_____ I understand that my physician has determined that my planned elective procedure/surgery is medically necessary and permissible under **Governor Abbott Executive Order GA-15 issued on April 17,2020**. I further understand that it is ultimately my decision whether to proceed with the procedure/surgery now or to wait to have the procedure/surgery until after the COVID-19 is less prevalent. I understand that family caregivers and visitors will be limited in an effort to reduce the spread of COVID-19 infection and practice social distancing. In the event that I developed any surgical complications or post-surgical complications, I understand that I may have to be transferred to a hospital for care. If I need to be admitted to a hospital I could potentially be exposed to patients with COVID-19.

_____ I have discussed with my physician the risks of proceeding with the procedure/surgery and with delaying the procedure/surgery. I have decided to proceed with the procedure/surgery. I understand that I accept full responsibility for any consequences of that decision. I agree that Bluebonnet Surgery Pavilion and my physician will not be held responsible or legally liable for my decision or any future consequences of my decision.

By signing below, I confirm that I have read, or have had read to me, and understand the above information. I am of sound mind, under no undue influence and an competent to make this decision and do so of my own free will.

Patient Signature: _____ Date/Time: _____

Legal Representative Signature: _____ Date/Time: _____

Printed Name: _____ Relationship: _____

Witness: _____ Date/Time: _____