COVID-19 Pandemic Emergency Ophthalmic Treatment Consent Form

Patient name: _____

Age :_____

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

During the lockdown in the wake of the current Corona companion, I have come to the hospital by myself for Emergency Treatment.

I have been made aware of the fact that under the current pandemic all non-urgent ophthalmic care is not allowed.

If I am an asymptomatic carrier or an undiagnosed patient with COVID 19, I suspect it may endanger doctors and hospital staff. It is my responsibility to take appropriate precautions and to follow the protocols prescribed by them.

I am aware that I may get an infection from the hospital or from a doctor, and I will take every precaution to prevent this from happening, but I will not at all hold doctors and hospital staff accountable if such infection occurs to me or my accompanying persons.

In case I or my attendant get the COVID 19 infection after the visit to the hospital, I will inform the hospital authorities at the earliest, so that appropriate tracking of the patients/attendants and hospital staff present on the day of my visit can be done.

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to emergency treatment completed during the COVID-19 pandemic. If I hide my facts and relevant details and because of my knowing or unknowing behavior or action the hospital staff gets infected, I may be held responsible for appropriate compensation in the court of law.

_____

SIGNATURE/THUMB IMPRESSION OF PATIENT

Name_____ Date_____

Mobile No.: _____

Address: _____

Name of the Attendant: _____ Date: _____ Mobile No._____

_____

Signature of the Attendant

Name of the Doctor/Hospital Personnel _____ Date: _____

_____

Signature of the Doctor/ Hospital Personnel