COVID-19 Screening

Name:_____

Please complete this form in an honest and thoughtful manner. If you are at higher risk, we may postpone your operation/consultation, or utilize different strategies to maximize your safety.

Please answer each question by checking the box YES or NO.

Yes	No	
☐	☐	Have you traveled, or have you had close contact with someone, who has traveled within the past 14 days by plane or train.
☐	☐	Have you had close proximity > 5 minutes to a lab-proven COVID-19-positive or Person Under Investigation within the last 14 days?
☐	☐	Has anyone in your family or close work associates had confirmed, possible or suspected COVID-19 in the last 14 days?
☐	☐	Do you work in a higher-risk occupation, such as health care worker, first responder, front-line service worker, or grocery store/airline/worker?

Do you have any of the following Symptoms:

YES	NO	
☐	☐	Fever (100.0°F)
☐	☐	Shortness of Breath, cough or other respiratory symptoms
☐	☐	Muscle aches/pain
☐	☐	GI symptoms (nausea, vomiting, diarrhea)
☐	☐	Loss of appetite
☐	☐	Loss of taste or smell
☐	☐	Conjunctivitis
☐	☐	Chills / repeated shaking with chills
☐	☐	Extreme fatigue

Signature: _____ Date: _____

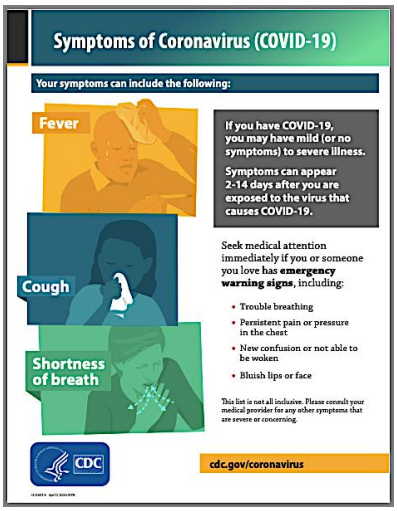
Remember: Please wear your Face Masks during your visit.

COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

☐ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.



☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

☐ _____ _____

Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**

The Aesthetic Society®

Notice and Disclaimer. Medical information changes constantly. This COVID-19 Informed Consent Agreement sets forth the current recommendations of The Aesthetic Society, is provided for informational purposes only, and does not establish a new standard of care. April 28, 2020

Important PREOPERATIVE and POSTOPERATIVE INSTRUCTIONS for your **UPCOMING SURGERY** during the COVID-19 Pandemic

At Glassman Plastic Surgery, our top priority is the **Safety and Health** of our patients and staff. To enhance your safety during the Covid-19 outbreak, we have instituted the following changes:

SPECIAL PREOPERATIVE INSTRUCTIONS:

1. All patients will sign a COVID-19 consent, in addition to the normal consent.
2. To minimize the added risks of having an operation while you have Covid-19, **All patients will get a COVID-19 test, shortly before the operation.**
3. **All patients should self-isolate beginning 14 days before their operation**
    a. Inform Dr. Glassman of any symptoms of Covid-19 as outlined below, or have had any contact with a suspected or confirmed case of Covid-19.
        i. FEVER COUGH
        ii. SORE THROAT
        iii. DIFFICULTY BREATHING
        iv. HEADACHE
        v. MUSCLE ACHE
        vi. VOMITING OR DIARRHEA
        vii. RECENT CHANGE IN TASTE OR SMELL
    b. Wear a face mask covering when in public
    c. Avoid Trips away from home.
    d. Maintain Social Distancing
4. **If you test positive for Covid-19, your surgery will be postponed a minimum of 21 days after testing positive and symptom free, and ONLY after testing negative again as above.**

SPECIAL POSTOPERATIVE INSTRUCTIONS:

1. After surgery, **continue to socially isolate for at least 7 days.**
2. Notify Dr. Glassman if you develop any symptoms suggestive of Covid-19
3. Call for any questions or concerns: 845-354-7878.

Lawrence S. Glassman, MD, FACS
Assistant Clinical Professor of Plastic Surgery
Albert Einstein College of Medicine, Montefiore Medical Center
Certified by The American Board of Plastic Surgery
American Society of Plastic Surgeons
American Society for Aesthetic Plastic Surgery
Overall Chair: American Society of Plastic Surgeons In Service Examination
Chair: American Society of Plastic Surgeons Comprehensive Aesthetic and Breast Examination

Important Instructions for your **Upcoming Appointment**
at
Glassman Plastic Surgery

At Glassman Plastic Surgery, our top priority is the **Safety and Health** of our patients and staff. To enhance your safety during the Covid-19 outbreak, we have instituted the following changes:

1. If you have any of the following symptoms, *PLEASE* **Reschedule your appointment.**
    a. FEVER
    b. COUGH
    c. SORE THROAT
    d. DIFFICULTY BREATHING
    e. HEADACHE
    f. MUSCLE ACHE
    g. VOMITING OR DIARRHEA
    h. RECENT CHANGE IN TASTE OR SMELL
    i. RECENT EXPOSURE TO COVID 19 VIRUS

2. When you **arrive in the parking** lot, **call the office** to let the office know you are here. **Wait in your car** until you are notified that your room is open, and then proceed into the office.

3. When you enter our facility, you will be asked to comply with the following:
    a. You must **wear a face mask** when entering our facility
    b. Complete a short Covid-19 **risk assessment form** (If you haven't filled this out on-line).
    c. **Temperature** by InfraRed forehead scan: If your temperature is higher than or equal to 100°F, you will be referred to your medical physician.

4. Following this initial assessment, you will be taken **directly** into your examination room.

Thank you for your help in kicking this virus back to the bats!

Lawrence S. Glassman, MD, FACS
Assistant Clinical Professor of Plastic Surgery
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