Dr. Fatima Khan | PR.Nr. 0810827
Specialist Physician / Nephrologist
MBBCh, FCP (SA), Cert Neph (SA)

T: 021 879 4694 W: www.drfkhan.co.za E: info@drfkhan.co.za
Suite 501, 5th Floor, Life Kingsbury Medical Suites, Wilderness Road, Claremont, Cape Town, 7708

COVID-19 PANDEMIC – DISCLOSURE AND CONSENT FORM

I, _____ (*name of person signing*), knowingly and willingly consent to a medical consultation; for myself or my child or person under my care: _____ (*name of person*) during the COVID-19 pandemic.

I understand that:

- People can contract COVID-19 from others who have the virus.
- The disease can spread from one person to another by either airborne droplets and direct contact on surfaces. This means coughing or sneezing or even speaking may spread fine droplets into the air and on surfaces, where the virus will live. The virus gains entry into the body via nostrils, eyes and mouth.
- This is why it is important to stay 2 metres away, especially from a person who is sick.
- COVID-19 virus has an incubation period of up to 14 days during which carriers of the virus might not show symptoms and still be highly contagious.
- Hospital and healthcare workers and staff may be asymptomatic carriers of the COVID-19 virus.
- I can contract COVID-19 by visiting the hospital, by being kept in a ward or at a doctor's consultation rooms.
- Some people can die from contracting COVID-19.

1) I hereby confirm that:
   a) That I have not knowingly been in contact with a COVID-19 positive person/persons or been in contact with a person/persons with respiratory symptoms as described in (2)
   b) I do not have a:
      (i) Cough
      (ii) Sore throat
      (iii) Fever
      (iv) Shortness of breath
      (v) Or atypical symptoms (*initial*)

2) I have been made aware that under the regulations under the state of national disaster (which regulations may vary from time to time), non-urgent/non-essential services or health care procedures may not be allowed (*initial*)

3) I understand that due to the presence of other patients, the characteristics of the virus, the nature of consultations and medical procedures, that I have an increased risk of contracting the virus, simply by being in a hospital or a medical practice (*initial*)

4) I understand that there is a risk that COVID-19 is fatal for some people and that it can cause permanent disability (*initial*)

I am of sound mind and understand the contents of the document. I hereby declare that all the information in this document is correct.

Signature: _____
(Patient/Guardian/Parent)

Witness: _____ Date: _____