THREE RIVERS HOSPITAL
www.threerivershospital.net
507 Hospital Way, Brewster, WA 98812
509.689.2517

THREE RIVERS FAMILY MEDICINE
www.brewsterclinic.org
415 Hospital Way, Brewster, WA 98812
509.689.3749

Consent to Treat During COVID-19 Pandemic

Patient Name (Please PRINT): _____

Interpreter requested? ❑ No ❑ Yes: Interpreter Name: _____

I am choosing to get health care that is elective and non-emergent.

I understand that I am getting care during the COVID-19 pandemic. It is easy for COVID-19 to spread from person to person. I am aware that the government recommends social distancing (keeping distance from others) to avoid this spread.

While **Three Rivers Hospital and Three Rivers Family Medicine clinic** follow state and federal infection control guidelines to stop spreading COVID-19, I know that I could still become infected by others who are present during my treatment. Those present may or may not know they are infected, and this adds a risk to moving forward with care.

By reading this form, I know that **Three Rivers Hospital and Three Rivers Family Medicine clinic** are taking these measures to protect patients and staff from COVID-19:

- Carefully choosing patients for elective care
- Social distancing when possible
- Screening staff and patients ahead of time
- Using Personal Protective Equipment (PPE)
- Infection control cleaning based on state and federal recommendations

Knowing the risks, I would like to move forward with my treatment. I have been given the choice to receive care at a later time. I am aware that I can talk about this option with my provider.

I confirm that I have read and understand this form. I have been given the chance to ask questions. My questions have been fully answered.

Patient or Legal Representative Signature: _____ Date: _____ Time: _____

Representative's Relationship to Patient: _____

Witness Signature: _____ Date: _____ Time: _____

*Adhere **Patient Sticker** Here*