GSM MEDICAL CENTER
DIP 1, GREEN COMMUNITY, EUROPEAN BUSSINESS CENTER
GROUND FLOOR SHOP NO: 29
Tel : 04-8831002, 04-8831003 Fax : 04-3399419
EMAIL: info@gsmmedicalcenter.com
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GSM Medical Center

# GENERAL CONSENT FORM

**Patient Name:** _____ **Age:** _____ **Patirnt #** _____

1. I am asking for medical care and treatment at this facility and agree to accept service which may diagnose a medical condition, procedures to treat my condition, routine dental and medical care, I have NOT been guaranteed as to the result to the services I will receive.
2. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment is completed.
3. I understand that my agreement to accept these services is called " **consent** " and that it includes any routine procedure (s) or treatment (s) such as blood drawing, physical examination, administration of medication(s), taking X-ray(s), use of local anesthesia, other non-invasive procedures OR invasive procedures.

   (**SPECIFY:** _____ )
4. Financial Agreement:

   I agree whether he/she signs as agent or as a patient that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the clinic bill unless the eligibility is NOT proved for free of charge services.

   Furthermore it is clearly understood by the undersigned that the estimated charges may differ from the final bill depending upon the actual services rendered. It is understood that the running bill of the clinic should be settled within the specified period of the time during the stay at the clinic.

_____
Signature of Patient or Legal Guardian of Minor Patient

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I confirm that I have explained to the patient/nearest relative of the patient the above mentioned procedure.

_____
Consent Taked by ( Physician / Nurse )

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Interpreter/Translator

*( To be signed by the interpreter/translator if the patient required such assistance )*
To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

Signature of interpreter/translator _____

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# TRAVEL DECLARATION FORM

Dear Sir/Madam,

In order to ensure the continuous well being of your health and staff community. As per the current prevention and control policy of **COVID-19 ( New Coronavirus )**, we request you to provide information regarding your travel history in the last 14 days from February 2020, please report and update regularly in case of travel.

Please complete the form below.

Name: _____

History of travel in the last 14 days: ☐ Yes ☐ No

Close relative history of travel: ☐ Yes ☐ No

Country visited: _____

Date of travel: _____

Duration of Stay: _____

Any history of contact with confirmed COVID-19 case: ☐ Yes ☐ No

Fever of flu symptoms during or after return from travel: ☐ Yes ☐ No

Contact Number: _____

Other Notes: _____

_____

I hereby declare that the details furnish above are true and correct to the best of my knowledge and belief, and I undertake the responsibility to inform you of any changes therein, immediately.

Name: _____

Date of Declaration: _____

Signature: _____

Your cooperation will help the well-being of all of us.

**APPENDIX 1: PATIENT SCREENING FORM**

| **Patient Screening Form**<br>**Patient Name:** | **Pre - Appointment Date:** | **In-Office**<br>**Date:** |
|---|---|---|
| Do you have fever or felt hot or feverish recently ( 14-21 days) ? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Do you have shortness of breath or breathing difficulty ? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Do you have a cough ? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Do you have any symptoms like gastrointestinal upset, headache or faigue ? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Have you experienced recent loss of taste or smell ? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Are you in contact with a COVID-19 Positve patient (s) ? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Are you above 60 years of age ? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder? | ☐Yes<br>☐No | ☐Yes<br>☐No |
| Have you travelled in the past 14 days to any regions affected by COVID-19 | ☐Yes<br>☐No | ☐Yes<br>☐No |

Note: Positive responses to any of these would likely indicate a deeper discussion with the

Dentist before proceeding emergency or urgent treatment.