Coronavirus (COVID-19) Waiver & Questionnaire

Pacific In Vitro Fertilization Institute would like to keep you, your family, our staff, and the community safe and healthy by practicing all social distancing recommendations following the CDC and local government guidelines. The best way to prevent illness is to avoid being exposed to this virus.

All Pacific IVF patients acknowledge that they will do the following during the process of their cycle:

- Clean my hands often, either with soap and water for 20 seconds or an alcohol-based hand sanitizer when hand washing is not available
- Avoid close contact with people who are sick
- Stay at home as much as possible
- Put distance between myself and other people (at least 6 feet)
- Cover my mouth and nose with a cloth face cover when around others
- Cover my cough or sneeze with a tissue, then throw the tissue in the trash
- Clean and disinfect frequently touched objects and surfaces daily
- Limit all nonessential travel

If there are any changes in my health, I will notify Pacific IVF immediately.

	Y	N
1. Have you traveled off island within the last 14 days?		
2. Have you been diagnosed with or suspected of having COVID-19 infection in the past 14 days?		
3. Have you been COVID-19 positive and recovered, do you have medical evidence of clearance?		
4. Have you lived with individuals diagnosed with or suspected of having COVID-19 infection within the past 14 days?		
5. Are you feeling unwell or exhibiting any of the symptoms below? Please circle all that apply. Cough / Shortness of breath or difficulty breathing / Fever / Chills / Repeated shaking with chills / Muscle pain / Headache / Sore throat / New loss of taste or smell		
6. Have you travelled to an area at high risk for COVID-19, nationally or internationally? https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html		

X_____ _____

Print Name Date

X_____

Signature

Any patient undergoing an egg retrieval or showing signs / symptoms of COVID-19 will be required to complete COVID-19 Antigen testing as needed. I understand that the cycle will be canceled if the required testing is not completed. I understand that a positive COVID-19 Antigen test will result in the cycle being canceled. I understand that I may be responsible for the cost of the test and any additional testing if needed. I understand that there is limited knowledge on the impact of COVID-19 regarding reproductive care, pregnancy, fetus, and neonate.

X_____ _____

Signature Date