

**Appendix 1:** Subgroups identified as key areas for assessment and recommendation in the study.

	Subgroup
1	Pre Clinic visit
2	Clinic disinfection/ preparation
3	Guidelines for staff
4	Guidelines for Doctors
5	During procedure guidelines

## **APPENDIX 2**

### **Pre-visit questionnaire to determine the risk profile prior to consultations or procedures**

(Please answer Yes/ No)

#### **SECTION A**

1. Were you tested positive for COVID- 19?
2. Where you in contact with COVID-19 patients?
3. Do you have you any history of fever ( $>37.5^{\circ}\text{C}$ ), cough, diarrhea, pneumonia, severe fatigue, muscle ache, conjunctivitis, the loss of sense of taste and smell, discoloration of the toes/fingers, and skin rash during the last 30 days?
4. Any history of living in or visiting a known COVID- 19 containment zone.
5. Have you travelled outside the city/ to a containment zone during the last 30 days?
6. Were you non-compliant during the lockdown process?
7. Do you go outside without a face mask?

#### **SECTION B**

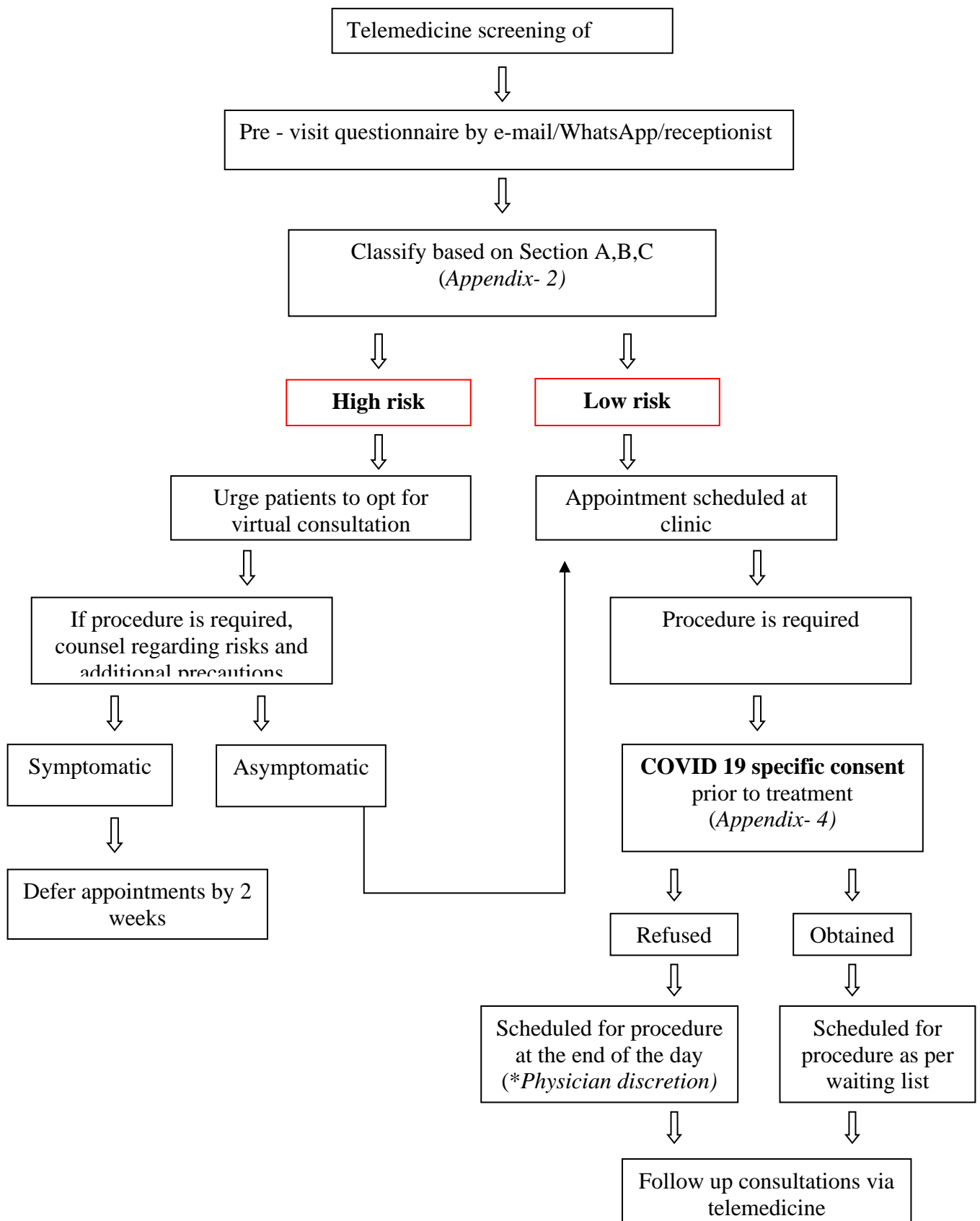
1. Age - Above 65years?

#### **SECTION C**

1. Co-morbidities
  1. Diabetes mellitus
  2. Hypertension.
  3. Cerebral vascular disease
  4. Chronic lung disease or moderate to severe asthma
  5. Obesity
  6. Pregnant or immediately postpartum
  7. Immunocompromised state - malignancy, smoking, transplant patients, immune deficiencies, HIV or AIDS, use of steroids, immunosuppressant therapy
  8. Ischemic and valvular heart disease.
  9. End-stage kidney disease

**If any of the questions above is answered with ‘Yes’ then the patient must be categorized as ‘high risk’ whereas ‘No’ will qualify them as ‘low risk’ patients.**

### Appendix 3: Pre Visit Patient flow algorithm



## **APPENDIX 4 Patient Consent form- Recommendation**

### **COVID 19 Specific consent**

It has been explained to me in a language I understand that I, ..... have been scheduled for an elective procedure, ..... I recognize that Dr.....and all the staff at ..... (clinic name) are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective procedure. I understand that during this period of the COVID 19 pandemic, every procedure carries an additional risk as the patient, bystander, hospital staff or doctor maybe an asymptomatic carrier.

I understand that possible exposure to COVID-19 before/during/after my procedure may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death.

I understand that based on the clinic policies, if I am identified as a high-risk patient, additional precautions may be undertaken to ensure my and the clinic staffs' safety. I agree to bear the additional expenses for any and all Personal Protective Equipment (PPE) if used during consultation or procedures.

I have been given the option to defer my treatment to a later date. However, I understand all the potential risks, including but not limited to the possible short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure.

### **Patient Declaration**

This is to state that I, ..... declare that the information provided is accurate. I fully understand that any false information can put the healthcare workers attending to me at a high risk of contracting COVID-19 disease. I also give an undertaking that I currently do not suffer from any COVID 19 symptoms (fever, cough, difficulty in breathing, and /or loss of taste sensation or smell. I am visiting the clinic knowing that we are going through a COVID-19 pandemic and fully aware of the risk it entails. I also undertake that I will follow all protocols laid down by the clinic for my safety. I hereby understand that the doctor will take all possible precautionary measures to prevent such an infection. In the unlikely event of contraction of COVID 19 infection, I will not hold the doctor, clinic or its staff morally or legally accountable for the same.

Patient's signature

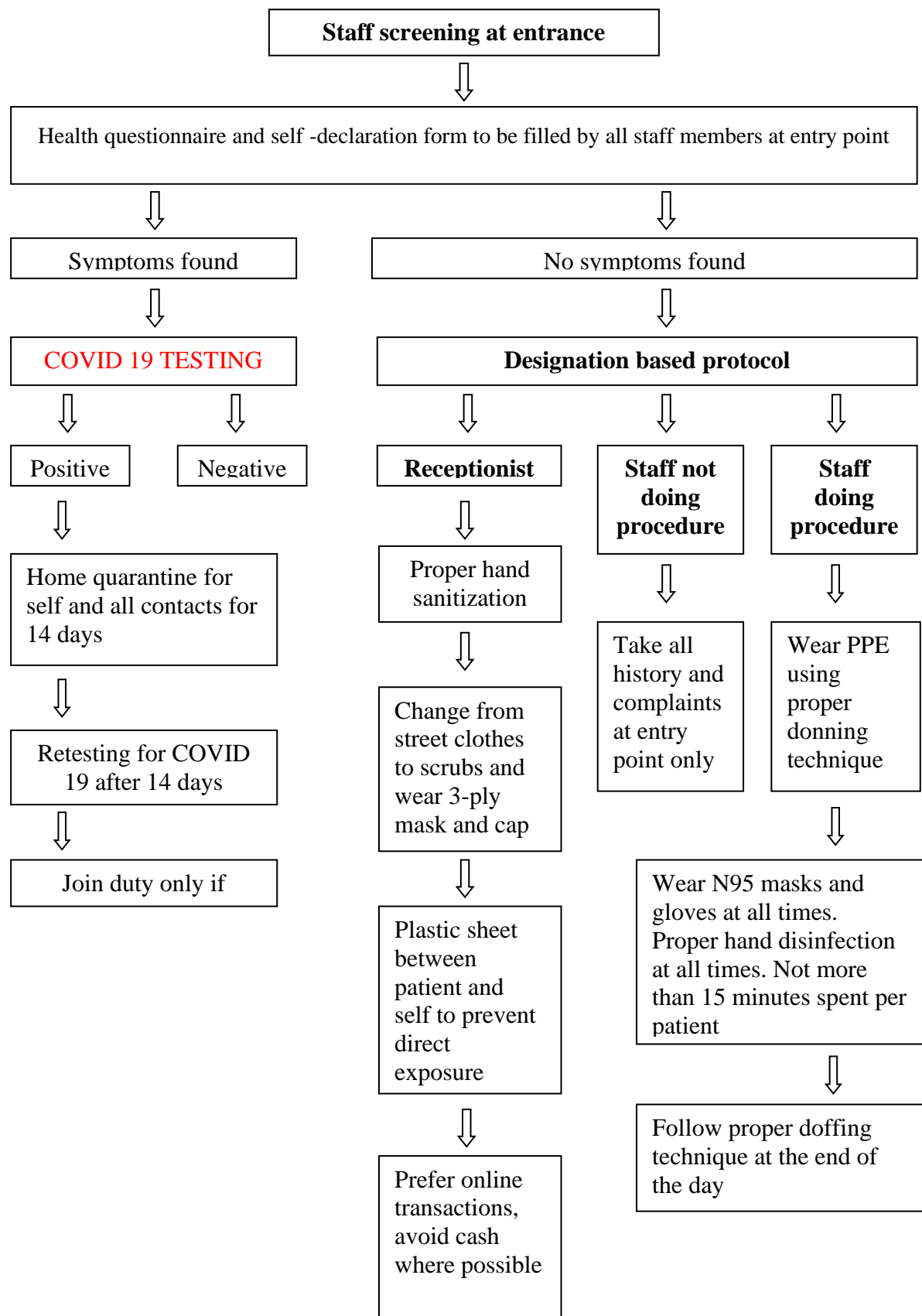
Doctor's Signature

Signature of the witness

Date

Date

Appendix: 5 Flow diagram for Clinic staff in all areas



## Appendix: 6 Protocol For Health Care Workers Performing Aesthetic Procedures

