

**INFORMED CONSENT FOR HOME ISOLATION / MEDICAL CERTIFICATE – COVID-19**

*(Fulfill when there is no label)*

Name of Organization: \_\_\_\_\_

Patient full name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Bed: \_\_\_\_\_

Admission Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time: \_\_\_\_\_ Registration: \_\_\_\_\_

Medical Director: \_\_\_\_\_ Medical License: \_\_\_\_\_

Considering legislation nº 356/GM/MS, of 03/11/2020: Art. 3º the home isolation measure can only be determined by medical prescription, for a maximum period of 14 (fourteen) days, considering respiratory symptoms or positive laboratory results for SARS COV-2.

§ 1º The certificate issued by a physician/ medical professional that determines the isolation measure will be extended to people residing in the same address, for all purposes, including the provision in § 3º art. of Law nº 13.979, of 02/06/2020.

§ 2º In order to issue the medical certificate referred to in § 1º, it is the duty of the symptomatic patient to inform the physician/ medical professional the full name of the other persons residing at the same address, **SUBJECT TO CIVIL AND CRIMINAL RESPONSABILITY FOR THE OMISSION OF FACTS OR PROVISION OF FALSE INFORMATION.**

I, \_\_\_\_\_, ID: \_\_\_\_\_,

PASSPORT: \_\_\_\_\_, resident and domiciled in \_\_\_\_\_

\_\_\_\_\_, Nº \_\_\_\_\_, District: \_\_\_\_\_, ZIP code: \_\_\_\_\_

\_\_\_\_\_, in the City of: \_\_\_\_\_, State: \_\_\_\_\_,

I declare that I was duly informed by the physician/ medical professional: \_\_\_\_\_

about the need of isolation to which I must be submitted, as well as people who lives in the same address or housekeeping employees, starting at \_\_\_\_ / \_\_\_\_ / \_\_\_\_ and ending at \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_, location the measure will take place:

( ) cited above or at the address: \_\_\_\_\_.

Name of people residing at the same address who must comply with the home isolation measure:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

I also declare that I am aware of the risks if not compliant with the isolation orientations for other individuals and the community, being aware of the consequences related to public health and legal issues.

**PATIENT/ REPRESENTATIVE SIGNATURE**

\_\_\_\_\_

**TO BE FILLED OUT BY THE PHYSICIAN**

I inform that I fully clarified the patient/ representative about the isolation and public health measures that the patient is subjected to, as well as the risks of complying with isolation/ quarantine requirements. All doubts and questions related to the topic made by the patient / representative were answered and clarified. Patient/ representative is in condition to understand and agree with what was informed, being aware of his (her) responsibility with the current measures, and must follow the following orientations:

- Keep the patient in a well-ventilated room individual room. In case a private room is not available, keep a distance of at least 1 meter from the patient;
- Limit the number of caregivers and not receive visits;
- Limit the circulation of the patient and verify if the shared environments (eg: kitchen, bathroom) are well ventilated (keep the windows open);
- The caregiver should use a surgical mask adjusted to face when in the same room and while manipulating the patient. The masks should not be touched or handled during use. If the mask gets wet or dirty with fluids, it must be replaced immediately;
- Discard the surgical mask immediately after use and proceed with hand hygiene using water and soap or alcohol gel;
- Use disposable paper towel to dry hands, preferably. In case paper towels are not available, use cloth towels and change when wet;
- Respiratory etiquette must be practiced by everyone. Cover mouth and nose when coughing and sneezing by using surgical mask, paper tissue or flexed elbow, followed by hand hygiene;
- Discard the materials used to cover mouth and nose immediately after use, followed by hand hygiene;
- Avoid direct contact with body fluids, especially oral or respiratory fluids and feces. Use disposable gloves to provide oral or respiratory care and when manipulating feces, urine and waste. Perform hand hygiene after removing the gloves;
- Gloves, masks and other waste generated by the patient or during the care of patients should be placed in recipients in the patients room before discarding with other domestic waste;
- Avoid sharing toothbrushes, cutlery, food, drinks or bed linen;
- Cutlery and dishes must be cleaned with water and detergent after use and can be reuse;
- Clean and disinfect frequently touched surfaces, such as bedside tables, bed frames and other furniture in the patients room daily with domestic disinfectant;
- Clean and disinfect the bathroom surfaces at least once a day with domestic disinfectant;
- Patients clean and dirty clothes, bed linen, bath and hand towels should be washed with water and laundry detergent. Avoid shaking dirty clothes;
- Use disposable gloves and protection clothes (e.g. plastic apron) to clean or handle surfaces, clothes, or surfaces with body fluids. Remove the apron before removing the gloves and wash hands immediately after;
- Patients must be at home until the complete resolution of signs and symptoms;
- Individuals who may have been exposure to suspected cases of SARS-CoV2 infection (including caregiver and health professionals) must be advised to monitor their health condition for 14 days, from the last day of possible contact, and look for immediate medical attention if any symptoms are developed, specially fever, cough or shortness of breath;
- Symptomatic individuals that had contact with the patient should get in touch with the health care service informing them of their arrival and during the transport to the health unit, wear surgical mask at all times and avoid using public transportation. It is advised to call an ambulance or use a private vehicle with good ventilation.

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Legible name, CRM\* and 'check' or stamp with CRM\* and 'check'  
 \*(physician's license number)