



Thunder Bay Regional
Health Sciences
Centre

CARE PARTNER, ESSENTIAL CARE PARTNER CONSENT TO RISK OF VISITING PATIENT (COVID-19)

Place Patient Label with
Barcode Here

Guidelines:

1. Designated Essential Care Partners (ECP) or Care Partners (CP) approved to visit a patient as part of an exceptional circumstance (i.e. End of Life care or Labour and Delivery) are to complete this form if they choose to enter the room of a patient known or suspected to be infected with COVID-19.
2. The ECP/CP is given a copy of the signed ECP/CP Consent to Risk of Visiting Patient (COVID-19) Form for their personal records.
TBRHSC staff contact Infection Prevention and Control (IPAC) to notify if ECP/CP is suspected or known to have experienced a high risk exposure to COVID-19 during their visit and provide details. IPAC to contact the appropriate Public Health Unit to share ECP/family member name and contact information if determined a high risk contact.
3. Once completed, form to be maintained where patient is being treated until end of treatment.
4. Upon discharge/completion of treatment form is to be sent to Health Records for scanning into the patient's legal medical record.

CONSENT (To be completed by the ECP/CP)

I, _____, have been advised of my risk of being

 Name of ECP/CP
 exposed to COVID-19 while visiting _____, and

 Name of Patient

I confirm my understanding as follows:

- I understand that accepting this risk may be harmful to my health, under certain circumstances, and that if I contract COVID-19, as a result of this visit, it may result in severe illness, disability or death.
- I undertake to follow all TBH staff instructions designed to reduce the risk of contracting COVID-19, including wearing necessary personal protective equipment ("PPE"), following the correct method to put on and take off PPE, and following instructions as to when visits may happen and when they must end.
- I acknowledge that if it is determined that I experienced a high-risk exposure to COVID-19 during my visit, that I will follow all applicable public health guidelines including immediately self-isolating for 14 days and any other direction provided by the Public Health Unit.
- I confirm my understanding that the Hospital is required under the *Health Protection and Promotion Act* to share my contact information with the relevant Public Health Unit in accordance with Regulation 569, so that the Public Health Unit may follow up with me as needed.



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By signing this form, I am acknowledging I have read and understand the above and I am releasing Thunder Bay Regional Health Sciences Centre of any liability or medical claims resulting from my decision to visit this patient. I have had the opportunity to ask questions about the risks and have all my questions answered to my satisfaction.

Name

Telephone Number

Signature

Date (dd/mm/yyyy)

Signature of Witness