

Facility: _____

File no.: _____
Family name, first name: _____
Date of birth: _____ ☐ F ☐ M
yyyy-mm-dd
RAMQ no.: _____ Exp. _____
yyyy-mm
Mother's name: _____

CONSENT BY CAREGIVER IN A HOSPITAL, CHSLD, IR, FTR, PSR - COVID-19

For caregivers assisting relatives in a hospital, CHSLD, IR, FTR, or PSR during the COVID-19 pandemic

IDENTIFICATION OF CAREGIVER

FAMILY NAME: _____ FIRST NAME: _____
Print please *Print please*
Phone number: _____ City of residence: _____
Health insurance card number: _____ Date of birth: _____

To help you make an informed decision, you must fully understand the inherent risks associated with assisting a user/resident during the COVID-19 pandemic:

- When you visit a user/resident, you are increasing the risk that he or she, the other users/residents, and the personnel will contract COVID-19;
- When you visit a user/resident, you are increasing the risk that you, as an informal caregiver, will contract COVID-19;
- In addition, the people most at risk of developing complications after contracting COVID-19 are those aged 70 and over, and/or those who are more vulnerable due to underlying conditions such as cardiovascular disease, lung disease, high blood pressure, diabetes, and chronic renal disease, and/or those with a compromised immune system.

Based on the above, I, the undersigned, _____
Print please

- Certify that I have understood the above-mentioned associated risks;
- Attest that I have read the information about symptoms monitoring, hand hygiene, respiratory etiquette, and the use of personal protective equipment;
→ **In CHSLD, IR, FTR and PRS only:** certify that I have read the document entitled *Information sheet for informal caregivers and visitors whose loved one is institutionalized* (MSSS, COVID-19. Publication date: _____) and agree to comply with it;
- Will comply with the conditions and guidelines imposed by the hospital or the living environment (CHSLD, IR, FTR, PSR) or by the public health authorities in terms of infection prevention and control;
- Agree to wear personal protective equipment appropriate to the user's or resident's condition;
- Agree to undergo a screening test and to inform the living environment of the results, if required by the user's or resident's condition;
- Understand that if I fail to comply with the conditions and instructions imposed by the institution or by the public health authorities, the institution may terminate my right to visit;
- Acknowledge that the institution may terminate my right to visit at any time;
- Agree to this consent form being placed in the user's or resident's file at the hospital, CHSLD, IR, or FTR, or being given to the director of the PSR, who must keep a copy.

This consent is valid for as long as the restrictions related to the COVID-19 pandemic are in place in the hospital, CHSLD, IR, FTR, or PSR. I also understand that I am not required to give this consent and that I may withdraw it at any time.

Caregiver's signature _____

Date: _____
yyyy/mm/dd