Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my consent and authorize for the treatment of the following condition(s):

Dx. U07.1 – 2019-nCoV acute respiratory disease

and/or

Dx. J10.1 – Influenza due to other identified influenza virus with other respiratory

manifestations

Dx. Z20.89 – Contact with and (suspected) exposure to unspecified communicable disease - (this dx. is

used for prophylaxis treatment due to exposure to influenza)

By administering the following medication (for course of therapy, indicate expected frequency and duration, not to exceed one year) – Please check all treatments you agree to receiving:

Paxlovid (COVID-19 treatment therapy) Molnupiravir (COVID-19 treatment therapy)

Tamiflu (influenza treatment therapy)Xofluza (influenza treatment therapy)

Tamiflu (influenza prophylaxis therapy) Xofluza (influenza prophylaxis therapy)

I refuse all above listed Influenza and COVID-19 treatments

It is my decision to decline treatment intervention if I were to test positive for influenza and/or COVID-19,

regardless of the information that I have received about its importance and the risk of not receiving it.

I understand the consequences of my decision, including but not limited to, increased risk for disease progression,

hospitalization, and death.I understand that I may choose to receive treatment therapy at any time, understanding

receival is based on meeting treatment criteria and availability.

1. I have read, had explained and/or have been given a copy of the Educational Reference Sheet/Patient Facts Sheet for the above listed medications. I have had a chance to ask questions or ask for additional information. I believe I understand the benefits and risks of the above medications, and request that I receive the appropriate above listed medications in which I’ve chosen, or the person named above, for whom I am authorized to make this request, in the event that I am exposed to influenza, or become infected with influenza and/or COVID-19.

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Print Name of Resident or HCP/Decision Maker/Legal Guardian Relationship to Resident

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Signature of Resident or HCP/Decision Maker/Legal Guardian Date

**Below is for Facility Use Only**

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Check if verbal consent obtained Date Time

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Print Name of Witness #1 Print Name of Witness #2