

Form 1: **Eligibility assessment for accommodation in an isolation residential unit**

Name: _____

Date of birth: _____

Address (permanent/temporary residence): _____

Mobile no. (provide the address where the person can be reached during their stay):

Address where the person is staying:

(provide the address where the provider of transportation can pick up the person)

To be completed by the attending physician:

The SARS-CoV-2 infection has been confirmed by laboratory testing

☐ YES ☐ NO

A medical examination is required before admission to the residential unit (COVID outpatient clinic)

☐ YES ☐ NO

The person has permanent or temporary residence in the Republic of Slovenia

☐ YES ☐ NO

The person cannot carry out the isolation measure at their address of permanent, temporary residence or in other suitable premises

☐ YES ☐ NO

The person is completely independent in satisfying their daily primary and support needs

☐ YES ☐ NO

(note: if the response is NO, the person cannot be referred to the residential unit for isolation)

The person is in a stable health condition and does not require hospital treatment, and there are no indications of any symptoms of the coronavirus disease or are mild

☐ YES ☐ NO

(note: if the response is NO, the person cannot be referred to the residential unit for isolation)

A physician from the COVID outpatient clinic has been informed of the person's stay in the residential unit for isolation and will monitor the person in accordance with the Ministry's instructions

☐ YES ☐ NO

The following general practitioner has been informed of the person's planned stay in the residential unit for isolation:

_____ (first name and surname), employed at
healthcare provider _____ (name
of institution).

The following COVID outpatient clinic physician who will monitor the patient has been informed of the person's planned stay in the residential unit for isolation:

_____ (first name and surname), employed at
healthcare provider _____

(name of institution).

(inform and complete in cases where the patient has no selected personal physician)

Scheduled date for the conclusion of the isolation measure:

Name of attending physician (printed):

Date and place:

Signature and stamp of physician:

Person's consent

I, the undersigned _____ (first name and surname of person who will be placed in a residential unit for isolation), hereby confirm that I am unable to carry out the isolation measure at my address of permanent/temporary residence or in other suitable premises. I agree with my accommodation in a residential unit for isolation for the entire duration of isolation in accordance with the instructions of the attending physician. I hereby issue my consent to the Ministry of Health of the Republic of Slovenia for data and information collection and processing in order to organise transportation and accommodation in the residential unit for isolation included in this form.

Name (printed):

Date and place:

Signature:
