Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is currently impacted by limited visiting and requires in person visiting for emotional and psychological health reasons.

|  |  |  |
| --- | --- | --- |
| Nominated Visitor 1 | | |
| **Name** | **Address** | **Post Code** |
| Nominated Visitor 2 | | |
| **Name** | **Address** | **Post Code** |

**DECLARATION**

As the nominated representative for Patient/Resident (Patient/Resident’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

agree to all the terms and conditions set out for visiting at Euroa Health these include

* *RAT test at the point of each entry*
* *Wearing the required PPE whilst visiting*
* *Not removing the required PPE whilst in the building*
* *Visiting only in the residents’ rooms*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed by Nominated Visitor No 1

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed by Nominated Visitor No 2

**Please return this form to** [**Paula.Mcpherson@euroahealth.com.au**](mailto:Paula.Mcpherson@euroahealth.com.au)

Form Approved by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date / /2022