**ENROLLMENT FORM**  

**NAME:** Mr/Mrs/Ms **…………………………………………………………………………………………………….……**

**FATHER NAME / HUSBAND’S NAME:** Mr/Mrs/Ms/Lt **……………………………………………………………**

**AGE: ……………………………. YEAR DATE OF BIRTH: ………………………………. SEX: …………………………**

**ADDRESS: ……………………………………………………………………………………………………………………………..**

**DISTRICT : ………………………………PIN CODE : ………………………. POLICE STATION: ……………………….**

**CONTACT NUMBER: ………….……………………………… OCCUPATION:…………………………….………………**

**CARE GIVER NAME:** Mr/Mrs/Ms **…………………………………………………………………………………………**

**CAREGIVER CONTACT NUMBER: … ….………………………………………………………………………….…………**

**PACKAGE OPTED FOR:**

**WOODLANDS COVID CARE @ Home HOMECARE** (Rs 4,500/-) ………………………….

**WOODLANDS COVID CARE @ Home ADVANCED HOMECARE** (Rs 8, 500/-) ………………………..

**WOODLANDS COVID CARE @ Home COMPLETE HOMECARE** (RS 16,000/-) ……………………….

**ENROLLED BY:**

1) Website ………………………………… 2) In hospital cash counter …………………

If hospital cash counter

Cash

Credit/debit card

**SIGNATURE :**

**CAREGIVER SIGNATURE :**

**Mail ID for communication:**

**Phone number with Whatsapp & Webex (apps for video consultation):**

**All communication will be done in this mail ID and whatsapp number.**

**Phone number**

If hospital cash counter

Cash

Credit/debit card

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**UNDERTAKEN FOR SELF ISOLATION**

I, ….………………………… S/W,D/W of ……………………, resident of …………………………………… being diagnosed as a confirmed/suspect case of COVID-19, do hereby voluntarily undertake to maintain strict self-isolation at all times for the prescribed period.

During this period I shall monitor my health and those around me and interact with the assigned surveillance team( Woodlands COVID care team) daily as per the schedule and if on emergency in case I suffer from any deteriorating symptoms.

Woodlands will not take responsibility if any worsening of symptoms occurs however in such case Woodlands team will guide me to identify the next level of treatment and I may have to visit nearest COVID care for the same.

I am liable to be acted on under the prescribed law for any non-adherence to self-isolation protocol.

SIGNATURE

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

CONTACT NUMBER

**DECLARATION**

Patient name:

Age:

Address:

Sex:

**CO MORBIDITY:**

* DM
* HTN
* CKD
* Cardiac disease
* COPD /Br asthma/Emplysema
* CVA( Ischemic/Haemorragic)
* Under any immunosuppressive therapy such as
  + - * Steroids
      * Mycophenolate Moeftil
      * AZATHIOPRINE
* Connective tissue disorder like SLE
* Obesity
* OSA

**WHEN TO SICK MEDICAL ATTENTION:**

* SPO2  lower than 95% in RA
* Persistent pain /pressure on chest
* Mental confusion or inability to arouse
* Developing bluish discolouration of lips /face
* Any unusual symptoms
* If doctor feels

**Signature:**

**Caregiver signature:**