



CORONAVIRUS DISEASE 2019 (COVID-19) Guidance for Persons Under Investigation

You are being tested for the virus that causes coronavirus disease 2019 (COVID-19). Public health actions are necessary to ensure protection of your health and the health of others, and to prevent further spread of infection.

As a person under investigation for COVID-19, the North Carolina Department of Health and Human Services, Division of Public Health advises you to adhere to the following guidance until your test results are reported to you.

- o Remain at home until you are cleared by your health provider or public health authorities.
o Keep a log of visitors to your home using the form provided.
o If you plan to move to a new address or leave the county, notify the local health department in your county.
o Call a doctor or seek care if you have an urgent medical need.
o If a medical emergency arises and you need to call 911, inform the first responders that you are being tested for the virus that causes COVID-19.
o Adhere to all guidance set forth by the North Carolina Division of Public Health for Home Care of patients that is based on guidance from the Center for Disease Control and Prevention with suspected or confirmed COVID-19 that is found here: https://epi.dph.ncdhhs.gov/cd/coronavirus/nonhealthcare.html.
o Your health and the health of our community are our top priorities.

Provider: _____ Date: ____/____/____

By signing below, you acknowledge that you have read and agree to comply with this Guidance for Persons Under Investigation.

_____ Date: ____/____/____

WHO DO I CALL?

You can find a list of local health departments here: https://www.ncdhhs.gov/divisions/public-health/county-health-departments

Health Department: _____

Contact Name: _____

Telephone: _____



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Please complete this form if your patient declines to sign the Guidance for Persons Under Investigation.

I ordered a COVID-19 test and provided the Guidance for Persons Under Investigation to my patient. However, my patient declined to sign the Guidance.

Patient Name: _____

Provider: _____

Date: ____/____/____