Get COVID-READY

COVID Care Plan for Adults

It's important to have a plan in case you or anyone in your household gets COVID-19. If this happens, you will need to isolate at home.

Most people who are fully vaccinated and get COVID-19 will experience mild symptoms, just as you would for many other mild viruses. The majority of people will be able to manage their symptoms at home while isolating.

What is a COVID Care Plan?

The plan lists important information about you, your health, and the people in your household. You can share it with:

- your doctor
- other health workers
- hospital staff
- a friend or family member.

Which COVID Care Plan should I use?

Use this plan if you are an adult who is not a parent or legal carer of a child, or if you are an adult who has other adults in your care.

Visit www.qld.gov.au/covid-ready to find a plan for:

- Parents/Carers and Children
- First Nations people
  www.makethechoice.com.au

How to use this plan:

Step 1

Every person who lives in or regularly stays in your household should complete a plan.

Step 2

Keep it somewhere easy to find, like on your fridge, near your phone charger or bed.

Step 3

If you get COVID-19, use this plan.

SC2200027/0122

Further information

13 HEALTH - 13 43 25 84
134 COVID - 13 42 68

Scan the code to see where else you can get help and more information

Queensland Government

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COVID Care Plan

*Your personal information will be safe. Under the law, all health workers MUST keep your private information confidential.

Name:

Age: Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: ID number:

COVID-19 vaccination status:

First dose: Second dose: Booster: Medical exemption:

Any medical conditions:

Current medications:

Allergies:

Do you have a disability? (if yes, please provide the details of your carer or support services)

Do you have any health conditions?

Do you have a current care plan? (this could include a mental health plan or care plan for treatment of an existing health condition)

Are you currently receiving care for cancer? (if yes, what type of cancer?)

Complete this section if you test positive for COVID-19

Date your symptoms started:

Date you took your positive COVID-19 test:

Next of kin:

Relationship:

Their contact details:

Are there pets/livestock in your care? (this could be a household pet or livestock on your property)

- [ ] Yes
- [ ] No

If yes, please provide the details of who will care for your pets/livestock if you have to go to hospital:

If I/we need to go to hospital with COVID-19. I would like the following people to care for my pets/livestock:

Please list in order of preference. Are these people aware that you have nominated them?

	Name of proposed carer:	Address:	Phone number:	Discussed with proposed carer:
1.				Yes
2.				Yes
3.				Yes

Household members information

Member 1 - Dependant adult (an adult member of your household you care for who might be a person with a disabilty or health condition)

Name:

Age: Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: ID number:

COVID-19 vaccination status:

First dose: Second dose: Booster: Medical exemption:

Any medical conditions:

Current medications:

Allergies:

Do you have a disability? (if yes, please provide the details of your carer or support services)

Do you have a current care plan? (this could include a mental health plan or care plan for treatment of an existing health condition)

Complete this section if you test positive for COVID-19

Date your symptoms started:

Date you took your positive COVID-19 test:

Next of kin:

Relationship:

Their contact details:

Who will care for this person if you get COVID-19 and have to isolate or go to hospital?

Please list in order of preference, who will care for this person if you need to isolate or go to hospital.
Are these people aware that you have nominated them?

	Name of proposed carer:	Address:	Phone number:	Discussed with proposed carer:
1.				Yes
2.				Yes
3.				Yes

Please record any additonal information here:

Member 2

Name:

Age: Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: ID number:

COVID-19 vaccination status:

First dose: Second dose: Booster: Medical exemption:

Any medical conditions:

Current medications:

Allergies:

Do you have a disability? (if yes, please provide the details of your carer or support services)

Do you have a current care plan? (this could include a mental health plan or care plan for treatment of an existing health condition)

Complete this section if you test positive for COVID-19

Date your symptoms started:

Date you took your positive COVID-19 test:

Next of kin:

Relationship:

Their contact details:

Please record any additonal information here:

Member 3

Name:

Age: Date of birth: Phone number:

Address:

Email:

Medicare number: Expiry: ID number:

COVID-19 vaccination status:

First dose: Second dose: Booster: Medical exemption:

Any medical conditions:

Current medications:

Allergies:

Do you have a disability? (if yes, please provide the details of your carer or support services)

Do you have a current care plan? (this could include a mental health plan or care plan for treatment of an existing health condition)

Get COVID-READY

Complete this section if you test positive for COVID-19

Date your symptoms started:

Date you took your positive COVID-19 test:

Next of kin:

Relationship:

Their contact details:

Please record any additonal information here: