INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

PATIENT INFORMATION

1. **Please complete the following information:**

   Patient Full Name_____ Date of Birth: _____

   Patient Home Address_____

   Patient Phone Number_____

2. **Have you been exposed to someone who has tested positive for Covid-19?**
   ☐ NO ☐ YES **If yes when: _____**
3. **I have previously tested positive for Covid-19** ☐ YES; date_____ ☐ NO
4. **Do you live in a group home OR assisted living center OR long-term care facility OR a personal residence with any other individual over 60 years old?**
   ☐ YES ☐ NO
5. **Do you work in a hospital, long-term care facility or assisted living facility?**
   ☐ YES ☐ NO
6. **Are you experiencing any symptoms currently?** This will not affect your testing eligibility.
   ☐ YES; Please mark which below. ☐ NO

☐ Fever	☐ Muscle aches	☐ Headache
☐ Cough	☐ Nausea and vomiting	☐ Chills
☐ Shortness of breath	☐ Diarrhea	☐ Loss of taste or smell
☐ Tiredness, Fatigue	☐ Sore throat	Other: _____

TESTING DETAILS

SELECT ONE OR BOTH

_____A COVID-19 reverse transcription polymerase chain reaction (RT-PCR) diagnostic test **(SEND OUT)**

____ A COVID-19 **Rapid** Antigen diagnostic test

_____A COVID-19 **Rapid** antibody test

All tests used are authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA).

Please sign the following attestation: I attest that the information I provided today is correct to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

PINNACLE HEALTHCARE

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7. Please carefully read and sign the following informed consent:

a. I authorize PHC to conduct collection and testing for COVID-19, as ordered by an authorized medical provider.
b. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
c. I authorize my test results to be disclosed to my employer if referred to PHC by employer.
d. I acknowledge that a positive RT-PCR/antigen test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
e. I acknowledge that a positive antibody test result alone cannot determine if I am acutely infected.
f. I understand the testing unit is not acting as my medical provider, this does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
g. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I can receive a copy of this Informed Consent at my request. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

_____ _____

Patient/Guardian Signature Date

AGREEMENT FOR SELF-ISOLATION

Depending on your current symptoms and test results, the public health recommendations may be to remain isolated. It is important for you to comply with the following Isolation Agreement points in order to protect the public's health. Thank you for agreeing to cooperate.

Please agree to each of the following statements by initialing and signing below.

____ **I agree that if I am *symptomatic* and awaiting COVID-19 test results,** I will stay home away from others or under isolation peculations until results are available. Once results are available I will follow the appropriate recommendations.

____ **I agree that if I am *symptomatic* and tested POSITIVE for COVID-19 by PCR/antigen or serology**, I will stay home away from others or under isolation precautions until you have had no fever for at least 3 days (72 hours) without the use of medicine that reduces fevers; AND other symptoms have improved; AND at least 10 days have passed since symptoms first appeared.

____ **I agree that if I am *symptomatic* and tested NEGATIVE for COVID-19 by PCR/antigen or serology**, I will stay home away from others for a least 3 days (72 hours) without the use of medicine that reduces fevers AND other symptoms have improved.

____ **I understand that if I am *not symptomatic* and awaiting COVID-19 test results,** I do not require isolation but that I will take everyday precautions to prevent the spread of COVID-19.

____ **I agree that if I am *not symptomatic* and tested POSITIVE for COVID-19 by PCR/antigen**, I will stay home away from others or under isolation precautions until 10 days have passed since specimen collection.

____ **I agree that if I am *not symptomatic* and tested POSITIVE for COVID-19 by antibody**, I will use a cloth face covering while outside my home for at least 10 days since specimen collection and take everyday precautions to prevent the spread of COVID-19. I also will consider getting a PCR test to help determine if I am currently infected. If I am a healthcare worker or first responder, I will wear a surgical mask or respirator while provide patient care for 10 days after specimen collection.

____ **I agree that if I am *not symptomatic* and tested negative for COVID-19 by PCR/antigen or serology**, I do not require isolation but that I will take everyday precautions to prevent the spread of COVID-19.

_____ _____

Patient/Guardian Signature Date

_____

Relationship to Patient