Screening for Covid-19 Rapid Test

Patient Name: ____________________________ Date: __________________

Date of Birth: ________________________

1. Do you have a fever or above-normal temperature (>100.4 F)?
   - ☐ Yes
   - ☐ No

2. Are you experiencing shortness of breath or having trouble breathing?
   - ☐ Yes
   - ☐ No

3. Do you have a dry cough?
   - ☐ Yes
   - ☐ No

4. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?
   - ☐ Yes
   - ☐ No

5. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?
   - ☐ Yes
   - ☐ No

6. Have you traveled more than 100 miles from your home in the last 14 days?
   - ☐ Yes
   - ☐ No

7. Have you been requested to complete this test by your employer?
   - ☐ Yes
   - ☐ No

This test has been ordered by:
Sanjay Patel, PIC
NPI: 1629350731

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Signature

I would like a follow up call in the event of a positive test?

- ☐ Yes
- ☐ No

Please carefully read and sign the following Informed Consent:

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab or blood draw, as ordered by an authorized medical provider or public health official.
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 acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.
d. I understand the testing unit is not acting as my medical provider, this testing 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.
e. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent.

I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

____
Date

____________________________________ ____________________________________
First Name Last Name

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Signature