CONSENT FOR TESTING FOR COVID-19 UNDER STANDING ORDER OF PUBLIC HEALTH

Please complete the following information:	
Name (last, first):	**Date of Birth:** _____ /______ /__________
County of Residence:	**Phone:**
Zip Code of Residence:	**Sex at Birth:** ☐ Male ☐ Female
Doctor's Name:	**Doctor's Phone:**

Please mark any of the symptoms you are currently having:

☐ None ☐ Cough ☐ Fever ☐ Shortness of breath ☐ Sore throat
☐ Muscle pain ☐ Chills ☐ Loss of taste or smell ☐ Diarrhea

Please select your Race AND Ethnicity:

Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Other __________________	**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read the following informed consent:

a. I authorize this COVID-19 testing to be conducted through a nasopharyngeal or nasal swab, as ordered by an authorized medical provider or public health official.
b. I understand that I am not creating a patient relationship with the ordering physician by participating in this testing. I understand the entity performing the test is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results and my medical care. I agree I will seek medical advice, care, and treatment from my medical provider or other health care entity if I have questions or concerns, if I develop symptoms of COVID-19, or if my condition worsens.
c. I understand it is my responsibility to inform my medical care provider if necessary. I understand that a copy will not be sent to my medical provider for me.
d. I understand that my test results will be disclosed to the appropriate public health authorities as is required by law.
e. I acknowledge that a positive test result is an indication that I may need to self-isolate in an effort to avoid infecting others.
f. I acknowledge that a negative test result is not a guarantee that I am not currently infected with COVID-19 and I may still need to be in isolation or quarantine.

I, the undersigned, have been informed about the test purpose, procedures and possible benefits and risks. 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.

AGREEMENT FOR SELF-ISOLATION

If I am found to have COVID-19, it will be necessary to self-isolate in order to prevent the transmission of this infection to others. It is important for me to comply with this Isolation Agreement in order to protect the public's health and prevent further outbreaks of COVID-19.

a. I understand that if I am infected with the virus causing COVID-19, I may meet criteria for isolation.
b. I agree that if I currently have symptoms of COVID-19, I will remain in home self-isolation while I await my COVID-19 test results.
c. I agree that if my COVID-19 test results are positive, I will remain in home self-isolation until the date the health department releases me from self-isolation.
d. I agree that if my COVID-19 test results are negative, yet I have symptoms of illness, I will remain in home self-isolation until fever-free for 48 hours and my other symptoms are improved. We encourage you to contact your medical provider.
e. I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons and may be in violation of public health laws.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. 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 and to any required self-isolation that may result.

____ ______________________________

Signature of Patient/Guardian/Custodian Date

BioReference
LABORATORIES
an OPKO Health Company

COVID-19 NASAL/NASOPHARYNX REQUISITION

ACCOUNT

PHYSICIANS

PATIENT

COMMENTS

LAST NAME	FIRST NAME	MI

STREET	APT. #

CITY	STATE	ZIP	DATE OF BIRTH	AGE	GENDER
			MM/DD/YYYY		

PATIENT PHONE NO.	PATIENT EMAIL	COLLECTED (DATE/TIME)
		❑ AM ❑ PM

RACE
Caucasian African American Asian Native American Pacific Islander/Hawaiian
Unknown Other: ___________________

ETHNICITY
Hispanic Non-Hispanic or Latino

NASAL/NASOPHARYNX (SOURCE)

☐ TH68-0 Novel Coronavirus COVID-19 Nasal / Nasopharynx

<u>IMPORTANT</u>: Please be advised that when submitting specimen for testing, it MUST be received in 3 mL of universal or viral transport media (UTM/VTM), Roche cobas® PCR Media, liquid Amies media, or saline. Volumes lower than 3 mL increase the risk of Invalid results or Quantity Not Sufficient (QNS).

For vials that contain less than 3 mL of media (e.g. e-Swabs), you will need to add normal saline to bring the media volume to 3 mL in the vial before sending in for testing.

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