HealthCap
RISK MANAGEMENT SERVICES

NOVEL CORONAVIRUS (COVID-19) PATIENT TESTING CONSENT

Patient Information

All fields marked with * are required and must be filled.

First Name*: ______________________________ Last Name*:________________________________
Date of Birth MM/DD/YYYY*: ______/______/__________
Phone Number*: __________________________________
Enter phone number for results*: ______________________________

Guardian or Emergency Contact Details

First Name*:_________________________________ Last Name*:___________________________
Phone Number*:____________________________
Enter phone number for results:*__________________________________

Novel Coronavirus (COVID-19) Testing Consent

By my signature, I understand, agree, certify, and authorize the following:

1) I am the patient named above.

2) I authorize [Facility Name] hereinafter "Facility" to collect a specimen for COVID-19 testing.

3) I understand the nasopharyngeal collection procedure and possible risks:

- A thin cotton tip applicator is passed deep into the nasal passages
- The test may be uncomfortable and may trigger coughing and sneezing
- Some bleeding after the collection may occur, but is not expected
- Failure to obtain a deep swab may result in inaccurate test results

4) Facility will collect and send the specimen to _________________ for laboratory analysis and report of my specimen. I authorize ______________ to perform testing.

5) I understand the COVID-19 test is not 100% accurate, cannot be used to rule out an infection, and a negative test does not preclude the presence of COVID-19.

6) I understand that results are generally available within 48-72 hours but may be longer due to lab volume and processing times.

7) I understand _____________________________ will contact me only at the number provided on this consent whether the result is positive or negative. Positive results for COVID-19 are reported to the _______________ Department of Health.

SAMPLE

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This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.

8) I understand that test results will be sent to ______________________ and forwarded to ______________________________ for data collection purposes.

9) I understand Facility assumes no liability for the administration of the testing.

Patient Signature: ____________________________________

Date Signed: __________________________________

SAMPLE

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