PATIENT INFORMATION

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

Patient name:______________________________ Date of birth:______________________

Patient address:____

Patient phone number:____

2. **Do you live in a group home, assisted living center or other facility with more than 3 other people older than 60 years old**

❑ YES ❑ NO

3. **Do you work in a hospital, long-term care facility or assisted living facility?**

❑ YES ❑ NO

4. **Have you been in close contact (i.e. within 6 feet) with someone confirmed to have COVID-19?**

❑ YES ❑ UNKNOWN

TESTING ELIGIBILITY

COVID-19 diagnostic testing, authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA), will be used today.

5. **Please mark the symptoms you are currently experiencing:**

❑ Fever	❑ Muscle aches	❑ Headache
❑ Cough	❑ Nausea and vomiting	❑ Other
❑ Shortness of breath	❑ Diarrhea	
❑ Tiredness, Fatigue	❑ Sore throat	

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

6. **Please carefully read the following informed consent:**

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a finger stick, 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 continue self-isolate in an effort to avoid infecting others.

d. I understand that I am not creating a patient relationship with Med Afford Express Care by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibilty to take appropriate action with regards to my test results. I agree I will seek medical advise, 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 a potential for false positive or false negative test results can occur.

f. I voluntarily agree to testing for COVID-19.

7. **Please carefully read and comply with the following statement:**

a. I agree that if my COVID-19 test results are positive, I will remain isolated for 7 days from this day of testing OR until at least 72 hours after my symptoms have resolved, whichever is longer.

b. I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons.

c. I agree that I will not come into contact with any other person who is ill due to potential COVID-19 infection.

______________________________________ ________________

Signature of patient Date