Family Pharmacy Clinical Services

COVID-19 **TESTING** Consent Form

Which Test(s)? ☐Rapid Antigen($45) ☐PCR (No chg)

Patient Name: _____ **Date of Birth:** _____/_____/_____
First MI Last MM/DD/YYYY

Sex: ☐ **M** ☐ **F** **Race/Ethnicity:** _____ **Phone:** _____

Address: _____
Street or P.O. Box City State Zip

SSN:_____ **Email:**_____ **Results By:** ☐Email ☐ Text

☐**Medicare** ☐**Private Ins** _____**ID:** _____ **Grp#:** _____ **Relation:**_____

☐ **I certify that I have no insurance coverage. (*Please provide driver's license and insurance cards)***

Answer the following questions:	YES	NO
1. I have general questions about COVID-19.		
2. I regularly use tobacco or nicotine products.		
3. Have you possible been exposed to the Coronavirus in the past 2 weeks?		
4. Have you been in close proximity (within 6 ft) to someone who has been diagnosed or presumed to have COVID-19?		
5. Have you been in close proximity (within 6 ft) to someone who is sick but not diagnosed with COVID-19?		
6. Do you live, work or have visited a place where COVID-19 is widespread?		
7. Have you been asked or referred to get tested by a health care provider?		
8. Are you seeking a test to prevent possible spread of COVID-19 for travel, work or recreation?		
9. Are you seeking to prevent possible spread of COVID-19 where social distancing is not possible?		
10. Are you a resident in a setting where there is a high risk of COVID-19 transmission?		
11. Do you work in a special setting where there is high risk of COVID-19 transmission?		

Which of these symptoms have you had in the last 21 days?

☐ Fever, at least 100.3, feeling feverish	☐ Headache
☐ Dry coughm, new or worsening	☐ Sore throat, new or worsening
☐ Sinusitis or sinus pain	☐ Shortness of breath
☐ Loss of smell or taste	☐ Muscle pain/aches or joint pain
☐ Runny nose or stuffy nose	☐ Diarrhea
☐ Chills	☐ Nausea or Vomiting
☐ Feeling tired, fatigue	☐ **None**

Do you have any of the following conditions?

☐ High Blood Pressure	☐ Previous stroke or other neurological condition
☐ Heart Disease	☐ Liver Disease
☐ Diabetes	☐ Lung Disease
☐ Overweight or Obesity	☐ **None**
☐ Kidney disease or Dialysis	

Do you have any of the following conditions that weaken the immune system or make it harder to fight infections?

☐ HIV	☐ Moderate to severe asthma
☐ Cancer	☐ Taking Steroids
☐ Lupus	☐ On Chemotherapy
☐ Rheumatoid Arthritis	☐ On Immunosuppressants
☐ Solid organ transplant	☐ **None**

I certify that I am the patient and at least 18 years of age, or the legal guardian of the patient. I certify that the above information is true and correct. Further, I give my consent to Family Pharmacy to administer the test(s) I have requested above. I understand the intent the test(s). I understand these tests have been authorized by an EUA and are not cleared or approved by the FDA. I am requesting this test for my own edification and the potential safety of myself and others. I authorize the release of any information necessary for determining payment benefits under my insurance carrier or HRSA to Family Pharmacy and affiliates. I hereby release Family Pharmacy and all officers, directors, and employees from any and all liability arising from or in any way related to the administration of the test listed above.

Signature: _____ **Date:**_____