COVID-19 Testing Consent

1. Have you been exposed to someone with COVID-19 in the last 14 days? ☐ No ☐ Yes

2. Have you felt like you had a fever in the last 24 hours? ☐ No ☐ Yes

3. Do you have a new or worsening cough today? ☐ No ☐ Yes

4. Do you have any of these other symptoms today? Date of onset _____

   a. Shortness of breath or difficulty breathing ☐ No ☐ Yes

   b. Fatigue ☐ No ☐ Yes

   c. Muscle or Body aches ☐ No ☐ Yes

   d. Headache ☐ No ☐ Yes

   e. New loss of taste or smell ☐ No ☐ Yes

   f. Sore throat ☐ No ☐ Yes

   g. Congestion or runny nose ☐ No ☐ Yes

   h. Nausea or vomiting ☐ No ☐ Yes

   i. Diarrhea ☐ No ☐ Yes

5. Have you been tested for COVID-19, and are still awaiting test results? ☐ No ☐ Yes

Signature: _____

Print Name: _____ Date of Birth: _____

Address: _____Town:_____Zipcode: _____

Cell Phone: _____ (best way to reach you quickly)

Employer/Department: _____

County Insurance: ☐ Yes ☐ No

For Office Use Only

Temperature: _____ Pulse Ox: _____

Testing Site: SCPHC Other: _____

Person Performing Test: _____

Test Used: CepheidXGen Acculabs

Today's Date: _____ Time: _____

Result: _____ Patient notification date/time: _____