

# CAPITOL TRAVEL MEDICINE

## COVID-19 Testing Consent Form

Patient Information					
Last Name		First Name		MI	
DOB	Age	Ph#			
Home Address					
City		State	Zip	Country	
Gender	Race	Ethnicity		<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Not Hispanic/Latino

Answer the questions by circling Yes, No or Unknown:

First Test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Employed in Health Care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Symptoms as defined by CDC?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If Yes, date of onset: month/day/year? _____ / _____ / _____			
Hospitalized?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
ICU?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Resident in congregate care setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Please read the following informed consent:

- I authorize Capitol Travel Medicine (CTM) to conduct collection and testing for COVID-19 through a nasopharyngeal swab by an authorized medical provider.
- I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
- I understand that I am not creating a patient relationship with CTM by participating in testing. I understand that CTM 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. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
- I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
- I understand that, as with any medical test, there is the potential for false positive or false negative test results.
- 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.
- I consent to receive my test results by phone message.

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_