CAPITOL TRAVEL MEDICINE

COVID-19 Testing Consent Form

Patient Information					
Last Name			First name		MI
DOB	Age	Ph#			
Email (legible for sending results)					
Home Address			City		State
ZIP	Gender	Race	Ethnicity	☐ Hispanic/Latino	☐ Not Hispanic/Latino

Answer the questions by checking Yes, No or Unknown:

First Test?	☐ **Yes**	☐ **No**	☐ **Unknown**
Employed in Health Care?	☐ **Yes**	☐ **No**	☐ **Unknown**
Symptoms as defined by CDC?	☐ **Yes**	☐ **No**	☐ **Unknown**
If Yes, date of onset: month/day/year?	_____ / _____ / _____		
Hospitalized?	☐ **Yes**	☐ **No**	☐ **Unknown**
ICU?	☐ **Yes**	☐ **No**	☐ **Unknown**
Resident in congregate care setting?	☐ **Yes**	☐ **No**	☐ **Unknown**
Pregnant?	☐ **Yes**	☐ **No**	☐ **Unknown**

Please read the following informed consent:

a. I authorize Capitol Travel Medicine (CTM) to conduct collection and testing for COVID-19 through a nasopharyngeal swab by an authorized medical provider.

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 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.

d. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.

e. I understand that, as with any medical test, there is the potential for false positive or false negative test results.

f. 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.

g. I consent to receive my test results by phone message and/or email.

Patient/Guardian Signature: _____

Date: _____

Relationship to Patient: _____