



## Consent to Test for COVID-19 PCR Nasopharyngeal Swab

To be completed by **ALL PATIENTS RECEIVING A TEST**

Legal Name, Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone number \_\_\_\_\_ email \_\_\_\_\_

### Are you experiencing any of the symptoms listed below?

- |                        |      |    |         |
|------------------------|------|----|---------|
| 1. Coughing            | Yes, | No | Unknown |
| 2. Fever (>100.4F)     | Yes, | No | Unknown |
| 3. Shortness of Breath | Yes, | No | Unknown |

Have you traveled outside the United States in the last 14 days?      Yes      No

If yes, where have you traveled: \_\_\_\_\_

### PATIENT CONSENT:

COVID-19 PCR nasopharyngeal (NP) swab test Consent Form and Waiver. This consent provides Healthcare Solutions Centers, LLC (HCS) with your permission to perform a NP swab procedure to test for SARS-CoV-2 virus. Your company is following HCS COVID-19 Work Safety Program to provide you with a safe and healthy workplace. By signing this consent, you are indicating that you voluntarily consent to this procedure for the detection of SARS-CoV-2 virus. The test being administered involves a nasal swab that will be tested to indicate the potential presence of SARS-CoV-2 virus. During the time involved in receiving the results of this test, you will not be allowed to return to work, and you must stay home quarantine until your results are back. HCS will call you with your SARS-CoV-2 results. The results can take anywhere from 3-7 days. You should carefully monitor your own symptoms, and, notwithstanding the results of any testing, you must stay home and consult with HCS at (602)424-2101 if you experience symptoms of COVID-19. You have the right to discuss the proposed testing with HCS, to learn about the purpose, potential risks and benefits of any testing. Because of the ongoing public-health crisis, it may be necessary for HCS to share the results of your test with your HR department at your work. By signing below, you consent to the disclosure of such information as requested, recommended or required by federal, state, and local public health authorities. By signing below, you agree to release and waive any claim arising from your voluntary SARS-CoV-2 testing. Additionally, you agree to release and waive any claim that might arise against HCS and its designated providers and staff members for any risks, side effects, or complications resulting from the testing.

Name \_\_\_\_\_ Employer \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Tester \_\_\_\_\_ Date \_\_\_\_\_