COVID-19 IgG Antibody & RT-PCR Test Request and Consent Form

Please complete this form and provide a copy of insurance card and identification at the time of collection.

Patient Information: COMPLETED BY PATIENT (or, in case of Minor, a Legal Guardian)		
First Name:	Last Name:	Phone:
Address:		
City:	Zip Code:	County:
State:		
Date of Birth:	Age:	Sex: □ Male □ Female
Email:		
Additional Information required for testing:		
Does the patient live or work in a congregate setting (e.g., long-term care facility, shelter, group home, prison, jail)		
□ YES □ NO	Facility Name: Employee Occupation:	
Does the patient receive dialysis? □ YES □ NO		

CLINICAL INFORMATION: COMPLETED BY PATIENT	
Date of symptom onset: □ None	Does the patient have any underlying conditions?
Symptoms Observed: □ Fever □ Runny nose □ Tiredness □ Loss of smell □ Dry Cough □ Diarrhea □ Body Ache □ Loss of Appetite □ Nasal Congestion	□ None □ Immunocompromised □ Unknown □ Pregnant □ Diabetes □ Chronic Lung Disease □ Hypertension □ Chronic Liver Disease □ Cardiac Disease □ Chronic Kidney Disease □ Other

LABORATORY TESTING – COMPLETED BY PATIENT	
Has the patient been tested for influenza? Result: □ Positive □ Negative Test Type: □ Rapid □ PCR	□ YES □ NO
Has the patient been tested for any other viral respiratory illness? Result:	□ YES □ NO

COVID 19 TESTING – COMPLETED BY PATIENT	
Has the patient been tested for COVID-19? Result: □ Positive □ Negative Test Type: □ Rapid □ PCR	□ YES □ NO

I hereby acknowledge full and complete consent for testing and make request for:

☐ **RT-PCR Test** and/or ☐ **SARS-Cov2 IgG Antibody Test** (CHECK ONE OR BOTH).

I hereby request and authorize PMH Laboratory, Inc. and its designated subcontractor, who is an independent nurse/healthcare staffing agency not directly affiliated with PMH Laboratory, Inc., to collect this sample for me or the person named above for whom I am the legal guardian. In case of the SARS-Cov2 IgG Antibody Test, I affirm that I am physically able to have my blood drawn and have never had an adverse reaction to any phlebotomy services. I agree to remain in the general area for at least 5 minutes after collection of samples. Testing is for informational purposes only and should be discussed with a health care professional. PMH Laboratory, Inc., is not providing you with medical advice nor are they responsible for any outcome in your care or treatment. Please keep in mind that a positive result does not mean you are immune or cannot become re-infected. Please provide a copy of this form to your physician and/or healthcare provider for your medical records

I hereby release The PMH Laboratory, Inc. its principals, directors, members, employees, affiliates, suppliers, providers, subcontractors, successors, agents, their respective insurance carriers, the sponsor of this COVID-19 testing program,, its subsidiaries and affiliated entities, and their principals, directors, employees, affiliates, successors, or agents from any and all liability, injury or damage whatsoever arising from, or in any way connected with either the RT-PCR Test or SARS-CoV-2 IgG Antibody Test or the administration of same including, but not limited to, acts of negligence. I authorize my medical information provided herein, and the test results, to be shared with my physician/insurance/employer. I further consent and authorize to have a designated representative in my employer's HR Benefits department receive a copy of my test results as part of this sponsored COVID-19 testing program. The PMH Laboratory, Inc., will use and disclose your personal and health information in order to: treat you, receive payment for the care we provide, provide required disclosures to public health agencies, and our other health care operations which generally include those activities we perform to improve quality care. We have prepared a detailed NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES to help you better understand our policies in regard to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices.

This test was developed and its performance characteristics determined by PMH Laboratory, Inc. This test has not been FDA cleared or approved. This test has been authorized by FDA under an Emergency Use Authorization (EUA). This test has been validated in accordance with the FDA's Guidance Document (Policy for Diagnostics Testing in Laboratories Certified to Perform High Complexity Testing under CLIA prior to Emergency Use Authorization for Coronavirus Disease-2019 during the Public Health Emergency) issued on April 20, 2020. FDA independent review of this validation is pending. This test is only authorized for the duration of time the declaration that circumstances exist justifying the authorization of the emergency use of in vitro diagnostic tests for detection of SARS-CoV-2 virus and/or diagnosis of COVID-19 infection under section 564(b)(1) of the Act, 21 U.S.C. 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.

PATIENT SIGNATURE:_____DATE:_____

Clinician to Complete:	
Today's Date:	Location Name:
Clinician Name:	Lot # for RT-PCR: Expiration Date: