BinaxNOW COVID-19 Patient Report

Patient Information

First Name: _____ Patient Last Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ DOB: ___/___/_____ Gender: _____ Race: _____

Phone: _____-_____-_____ Ethnicity (circle one): Hispanic / Non-Hispanic / unknown

Testing Results (circle one): Positive/Negative

Procedural Control Results Valid (circle one): Yes/No

Facility Use Only

Kit Lot #: _____

Kit XP Date: _____

Kit Received Date: ____/____/____

Tester's Name: _____ Tester's Initials: _____ Date: _____

Reviewer's Name: _____ Reviewer's Initials: ____ Date: _____

****Isolation can be discontinued 10 days after symptom onset and the resolution of fever for at least 24 hours without the use of fever-reducing medications and with improvement of other symptoms.*

Informed Consent for COVID-19 Diagnostic Testing

Authorization/Consent

I voluntarily consent and authorize The Arc of Northeast Indiana to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample by The Arc of Northeast Indiana through a nasopharyngeal swab, oral swab, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

Acknowledgment/Release

I acknowledge and agree that XX may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

To the fullest extent permitted by law, I hereby release, discharge and hold harmless, XX, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.

By signing, I am acknowledging during the registration process for COVID-19 Diagnostic Testing with XX, I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.

Patient Full Name: _____ **Date:** _____

Parent/Guardian Full Name: _____ **Date:** _____