PIERCE COUNTY MASS TESTING CONSENT FOR TESTING & DEMOGRAPHICS

Name of test site:					
Do any of the following apply to you?	Student	Faculty	Resident	Employee	Other/ Not applicable

Name:			Date of Birth:
Email:			Cell Phone:
Address:			Zip Code:
City:			State:
Preferred Language (Circle one)	English	Spanish	Russian
	Korean	Vietnamese	German
	Tagalog	Other:	

Check all that apply	Race	Check all that apply	Ethnicity
	American Indian or Alaska Native		Hispanic or Latino
	Black/African American		Not Hispanic or Latino
	Native Hawaiian or Pacific Islander		
	Asian		
	White		
	Other Race		

Consent for Testing:

❑ **By checking the box, I agree to a text message and/or email communication to receive my COVID-19 test results. (Only negative results will come via text or email. Positive tests will result in a phone call to the number listed above).**

I authorize DispatchHealth to conduct collection and testing for COVID-19 through an anterior, mid-turbinate swab as ordered by a licensed medical professional.

I authorize my test results to be disclosed to the county, state, 'covered entity' or to any other governmental agency as may be required by law.

I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed to avoid infecting others.

I understand the testing unit is not acting as my medical provider, this test does not replace treatment by my medical provider, and I assume complete and full responsibility to take the 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 medical condition worsens.

I understand that, as with any medical test, there is the potential for a false positive (**test is positive but I do not have the infection**) or false negative (**test is negative but I do have the infection**) COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits, and risks, and I can request a copy of this informed consent.

I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Printed Name:_____Today's Date:_____

Signature:_____

FIDALAB

☐ **COVID-19** ☐ **Influenza A/B**

PATIENT INFORMATION

It is VERY IMPORTANT to write down your contact information for communication of your test result.

Telephone #: Email:

Last Name: First Name:

DOB: Sex:

☐ Female ☐ Male ☐ Other

Address of Residence: Apt #:

City: State: ZIP:

Race:

☐ American Indian or Alaskan Native ☐ Black or African American

☐ Asian ☐ Native Hawaiian or Other Pacific Islanders

☐ White ☐ Other Race

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

REPORTED SYMPTOMS

☐ Fever, unspecified (R50.9) ☐ Shortness of Breath (R06.02)

☐ Cough (R05) ☐ Others:_____

☐ Exposure to confirmed Covid-19 cases (Z20.828)

SAMPLE INFORMATION

Date of Collection:_____

PATIENT CONSENT

By signing this form, I, the patient having the testing performed, acknowledge that: (i) I have been offered the opportunity to ask questions and discuss with my healthcare provider the benefits, risks and limitations of the test to be performed; (ii) I have discussed with the healthcare provider ordering this test the reliability of positive or negative test results and the level of certainty that a positive test result for a given disease or condition serves as a predictor of that disease or condition; (iii) I have received and read the Patient Informed Consent in its entirety and realize I may retain a copy for my records; (iv) I consent to having this test performed and I will discuss the results and appropriate medical management with my healthcare provider.

X

Patient signature

Date:_____

MEDICAL NECESSITY

I certify that (i) this test is medically necessary. (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and Fida Lab's Patient Informed Consent. I agree to provide Fida Lab, or its designee, any and all additional information reasonably required for this testing to be performed and billed.

X

Healthcare provider signature

Date:_____

Reporting of Covid-19 testing result is mandated under Washington State Administrative Code (WAC) 246-101 (http://app.leg.wa.gov/wac/default.aspx?cite=246-101).