



Ivylea
PHARMACY

DATE _____

Time _____

Parking # _____

2446 Elmwood Ave Kenmore, NY 14217

NPI: 1144324104 Phone: (716) 873-1444 Fax: (716) 873-5496

COVID-19 Testing : Informed Consent

Please carefully read and sign the following Informed Consent:

1. I authorize Ivylea Pharmacy to conduct collection and testing for COVID-19 through a nasopharyngeal swab. Based on my results, additional testing may be needed for confirmation.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I understand that I am not creating a patient relationship with Ivylea Pharmacy by participating in testing.
4. I understand that Ivylea Pharmacy is not acting as my medical provider, this testing does not replace treatment by my medical provider, and 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.
5. I understand that the antigen test will produce one of two results; a positive test result indicates that antigens for SARS-CoV-2 were detected, and I am infected with the virus and presumed to be contagious. I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others. A negative test result means that antigens for SARS-CoV-2 were not present in the specimen above the limit of detection. However, a negative result does not rule out COVID-19 and should be treated as presumptive and confirmed a molecular assay, if necessary for patient management.
6. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received 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 and I acknowledge that I have read, understand, agree, certify and/or authorize the information above and further agree to hold harmless Ivylea Pharmacy, including its employees, agents, and contractors from any and all liability and claims.

_____ (Print Name)

Date _____

Signature of Patient/Legal Representative _____

THIS SECTION FOR OFFICAL USE ONLY

Date of Test _____ Time test administered _____ Results Read at _____

LOT _____

Expiration _____



Purpose Antigen tests are an important part of the COVID-19 public health emergency response strategy as these tests are relatively inexpensive and can be used at the point-of-care. However, they are generally less sensitive than PCR testing. The New York State Department of Health (DOH) provides these recommendations to support the effective use of antigen tests for different testing situations to ensure the most appropriate interpretation of antigen test results, which is important for accurate clinical and public health management.

Recommended Use:

- Use to test individuals when there is an outbreak in a public setting or environment
- Use to test residents and employees in nursing homes and adult care facilities regardless of outbreak status.
- Congregate facilities include nursing homes, assisted-living facilities, long-term-care facilities, and other health or social facilities such as day programs.
- Congregate settings include schools, colleges, universities and other educational settings, workplaces, and other sites where people gather.
- All antigen test results must be reported to ECLRS.

Considerations When Testing Individuals When There Is an Outbreak in a Public Setting

- If a **symptomatic** or **asymptomatic** individual has a **Positive** antigen test result, no confirmatory testing is needed. The individual must be isolated and contact tracing must be initiated immediately.
- If a **symptomatic** individual has a negative antigen test result, perform confirmatory laboratory-based RT-PCR test immediately and test for other respiratory pathogens. Quarantine until RT-PCR results are obtained and stay home from school or work. If confirmatory laboratory-based RT-PCR is positive, continue isolation and immediately initiate contact tracing. If confirmatory laboratory-based RT-PCR is negative discontinue quarantine.
- If an asymptomatic individual has a negative antigen test result, consider confirmatory laboratory-based RT-PCR test within 48 hours. If confirmatory laboratory-based RT-PCR is positive, isolate and initiate contact tracing immediately. If confirmatory laboratory-based RT-PCR is negative, discontinue isolation



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COVID-19 ANTIGEN TESTING PATIENT INTAKE FORM

LAST NAME _____ FIRST NAME _____ MI _____ SUFFIX _____

STREET ADDRESS _____ CITY _____

COUNTY _____ STATE _____ ZIP _____

HOME/CELL PHONE _____ WORK PHONE _____

DATE OF BIRTH: _____

MEDICAID NUMBER (IF APPLICABLE) _____

HEALTH INSURANCE PROVIDER _____ ID# _____ GRP# _____

PREGNANT Y / N (CIRCLE) GENDER _____

RACE CIRCLE ALL THAT APPLY:

BLACK/AFRICAN AMERICAN WHITE ASIAN AMERICAN INDIAN OR ALASKAN NATIVE
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER UNKNOWN OTHER

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

PHONE # _____ JOB TITLE _____

SCHOOL NAME AND ADDRESS _____

SCHOOL PHONE # _____ DISTRICT _____ TITLE _____

BEDS CODE (FOR SCHOOL EMPLOYEES ONLY) _____

IS THIS YOUR FIRST COVID TEST Y / N (CIRCLE)

ARE YOU A HEALTHCARE EMPLOYEE Y / N (CIRCLE)

WHEN DID THESE SYMPTOMS BEGIN? _____

CREDIT CARD NUMBER _____ EXP DATE _____ CVV _____

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