Plumsted Pharmacy
28 Brindletown Rd
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(P) 609-758-8829
(F) 609-758-0678

Consent for Rapid CLIA Flu A/B and Strep Testing

Please complete sections A, B, and C

Section A:

First Name: _____ Last Name:_____
Home Address: _____ City:_____ State:____ Zip:_____
Date of Birth: _____ Age:_____ Gender __M __F
Home Phone: _____
Primary Care Physician (if known): _____ Physician Phone: _____

Section B:

Requested Test: _____ Flu A/B _____Strep A

Do you have a Fever _____

How Many Days have you been feeling sick for (Please circle) 1-2 3-4 5 or More

Section C:

I certify that I am the Patient or guardian of a patient receiving a CLIA waived rapid strep or Flu A/B test. I give my consent to the health care provider Plumsted Apothecary Inc, as applicable to administer the test(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving these tests and all test results must be used as a component along with the advice and guidance of your healthcare provider. Positive test results should be brought to the attention of your medical doctor and used with their professional judgement as a course of treatment. Negative results do not mean that you should not follow up with your medical doctor if your condition does not improve or worsens. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Plumsted Apothecary Inc, as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and ally liabilities or claims whether known arising out of, in connection with, or in any way related to the administration of the test(s) listed above. I authorize Plumsted Apothecary Inc, as applicable to release any medical or other information to my health care professionals, as necessary with respect to the test(s) listed above.

Signature _____ (Parent/Guardian if under 18) Date_____

For Office Use:

Date of Test_____ Time _____

Testing Device Used : BD Veritor System

Group A Strep Test Device: Lot #_____ Expiration_____ Result: _____

Flu A/B Test Device: Lot #_____ Expiration_____ Result: _____

Test Administrator _____ Pharm D/ RPh
