PATIENT COVID SCREENING/CONSENT FORM

DIAGNOSTIC TESTING AND HEALTH SCREENING

KANAB UNITED DRUG

Patient Name (print)_____Date of Birth____ /____/_____

Adress:_____City_____State_____Zip_____

Phone: _____Email Address:_____

Gender: M____F____ Pregnancy Status: Yes___ No____

Ethnicity: Unknown_____Hispanic or Latino_____Not Hispanic or Latino_____Other_____

Race: White__Black/African American___American Indian___Alsakan Native___Native Hawaiian__

Pacific Islander___Unknown_____

Drug Allergies:_____

a. I authorize Kanab United Drug to conduct collection and testing for COVID-19 as ordered by an authorized medical provider or health official.
b. I understand, as required by law, my test results will be disclosed to the county, state, or to other government entity.
c. I understand Kanab Drug 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.
d. I understand that, as with any medical test there is a 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. 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 and have been given instructions how to obtain a copy of this informed consent. I voluntarily agree to this testing for COVID-19.

Patient Name (print)_____

Patient Signature _____

Representative Name (print)_____

Representative Signature_____

Signature of Witness if verbal consent obtained_____

Primary Care Doctor_____

Patient Questionnaire

Do you have any of the following medical conditions?

Hemoglobin Disorders___	Severe Heart Condition ___	Obesity ___
Cancer Treatment___	Kidney Disease that requires dialysis ___	HIV___
Moderate/Severe Asthma___	Corticosteroid Treatment ___	Diabetes ___
Bone Marrow/Organ Transplant ___	Immune System Disfunction___	

Is this the 1st time you have been tested for COVID-19?

Are you employed in a healthcare setting?_____ If no what is your occupation?_____

Are you experiencing any of the following symptoms?

Chills___	Shortness of breath___	Nasal discharge___
Vomiting___	Sore throat___	Nausea___
Nasal congestion ___	Cough___	Muscle pain___
Loss of sense of taste___	Loss of sense of smell___	Headache___
Fever over 100.4 F___	Feeling feverish___	Fatigue ___
difficulty breathing___	diarrhea____	

What date did you start experiencing symptoms?_____

Do you currently live in a congregate setting? If so what type of setting?_____

Method of Payment: Card number_____

Expiration date:_____ CVV Code____

FOR OFFICE USE ONLY

___POSITIVE ___NEGATIVE

COMPLETED BY_____