Patient COVID Screening/Consent Form
Diagnostic Testing and Health Screening
Township Professional Pharmacy

Patient Name (print):_____Date of birth____/____/_____
Patient Address:_____City_____State____Zip_____
Telephone:_____ 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___ Asian___ Alaskan Native___ Native Hawaiian___ Pacific Islander___ Unknown___
Drug allergies:_____

a. I authorize Township Pharmacy to conduct collection and testing for COVID-19 as ordered by an authorized medical provider or public health official.
b. I understand, as required by law, my test results will be disclosed to the county, state, or to other governmental entities.
c. I understand Township 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.
d. 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. 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_____Date_____
Representative Name(print)_____Relationship_____
Representative Signature _____Date_____
Signature of Witness if verbal consent obtained_____
Primary care Doctor _____Phone _____

Patient Questionnaire

Do you have any of the following medical conditions? Diabetes___ Obesity___ Moderate/Severe Asthma___ Serious Heart Condition___ Kidney Disease that requires dialysis___ Liver Disease___ Cancer Treatment___ Corticosteroid Treatment___ Bone Marrow/Organ Transplant___ Hemoglobin Disorders___ Immune System Dysfunction___ HIV___

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

Are you employed in a healthcare setting? If so, what is your occupation? _____

Are you experiencing any of the following symptoms? Chills____ cough____ Shortness of breath____Diarrhea____ Difficulty breathing ____ fatigue ____ feeling feverish____ fever over 100.4 F____ headache____ loss of sense of smell____ loss of sense of taste____ muscle pain_____nasal congestion____ nasal discharge____nausea____ sore throat ____ vomiting ____

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: _____CVV:_____

(For official use only)

BD Veritor Rapid Covid-19 TEST performed Date: _____

Results: Negative Positive

Health Department Notified: Yes No