LEXINGTON PRESCRIPTION CENTER NPI: 1750465357 800 S. MAIN ST., LEXINGTON, VA 24450 Ph: 540-463-9166 Fax: 540-463-9839 Jeffrey S. Goldstein – Owner, Laboratory Director NPI: 1548352701 CLIA ID #: 49D2173369	

Specimen ID: (for lab use)

PATIENT INFORMATION ☐ Rapid Covid Test ☐ PCR Covid Test ☐ Covid Antibody Test

NAME: Last First M.I.			**Home Phone:**
Date of Birth:	**Sex:** M F	**Email address**	**Cell Phone:**
ADDRESS: Street City County State Zip Code			

Race: Please check one

__ American Indian/Alaskan Native
__ Asian
__ Black / African American
__ Hawaiian/Pacific Islander
__ White
__ Unknown
__ Other: ___________________

Ethnicity: Please check one

__ Hispanic or Latino
__ Not Hispanic or Latino
__ Unknown
__ Other: _____________

Please circle the correct answer (Y=yes N=No U=Unknown)

1. Is this your first Covid test of any kind? Y N U
   If NO, have you ever tested POSITIVE for Covid? Y N U
   If so, when? ______________________________
2. Are you employed in Healthcare? Y N U
3. Were you a resident in a congregate care setting (nursing home, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting? Y N U
4. Are you pregnant? Y N U

When do you think you were exposed to Covid -19?
(testing should take place 5-7 days after exposure for best results)
Date of exposure: ____________________________________

Are you currently experiencing symptoms? Y N
(symptoms may occur 2-14 days after exposure to the virus)
Have you had symptoms within the past 14 days? Y N
Date of symptom onset: _______________________________

Symptoms - check all that apply: (testing should take place within the first 5 days after symptoms start for best results)

__ Fever or chills
__ Muscle or body aches
__ Congestion or runny nose
__ Cough
__ Headaches
__ Nausea or vomiting
__ Shortness of breath or difficulty breathing
__ New loss of taste or smell
__ Diarrhea
__ Fatigue
__ Sore throat

PHYSICIAN INFORMATION (Optional)

Practice Name:	Practitioner:
Phone #:	Fax #:

CONSENT AND RELEASE

To agree to participate in this test, please initial boxes, sign, print name and date this form. Thank you.

☐ *I have read, and I understand the "Fact Sheet for Patients" provided to me.*

☐ *In consideration of my participation in this test, I hereby agree to assume all risks. I also understand that results are not designed to replace the care or advice of a medical provider. I understand that if I receive abnormal laboratory test results, I should promptly consult with a physician.*

☐ *This test will not be billed to insurance by Lexington Prescription Center. You will receive a receipt and invoice after testing to submit to insurance if you chose. Coverage is not guaranteed. Your insurance may reimburse the full amount, a portion of the amount, or not at all.*

____
Signature of Participant
(or parent or legal guardian if patient is under 18 years of age)

____
Printed name of participant
(or parent or legal guardian if patient is under 18 years of age)

____
Date

For Lab use only:

SPECIMEN COLLECTION INFORMATION

Collection Date Time Initials	**SPECIMEN SOURCE:** *Double swab of internal nose (SCT)*	**Remarks:**

SARS-CoV2 TEST RESULTS - BD Veritor System for Rapid Detection of SARS-CoV2 Antigen in Respiratory System

Testing date: Tested by: ☐ Presumptive negative test for SARS-CoV-2 (no antigen detected) *260415000* ☐ Positive test for SARS-CoV-2 (antigen present) *260373001*	Remarks:

Payment Information:

Patient Name: ________________________________ Date of Birth: ________________

Name on Credit Card: ____

CC#: ____

Exp: _______________ CVV: _______________ Billing Zip Code: _______________

Visa Mastercard American Express Discover Debit Card

By singing below, I authorize Lexington Prescription Center to charge the credit card/ debit card information I have provided. I also affirm that I have been made aware Lexington Prescription Center does not submit claims to insurance for COVID-19 tests and I am responsible for seeking reimbursement.

Signature: ___________________________________ Date: ___________________

Vehicle Description:

Make: ____

Model: ____

Color: ____