Mills Family Pharmacy
Compounding Center and Gift Shoppe
2994 S Church Street Murfreesboro, TN 37127
Phone: (615)- 895- 1641

**Covid-19 Antibody Test**

Name (last, first):_____ Date of Birth:_____

Phone:_____ Address:_____

City:_____ State:_____ Zip:_____

Email:_____ Gender: ☐ Male ☐ Female ☐ Other

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

Allergies:_____ ☐ No known allergies

Please answer the following questions to the best of your knowledge and understanding:

1. Are you sick today? (fever, chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste/smell, sore throat, congestion, runny nose, nausea/vomiting/diarrhea?) ☐ Y ☐ N

2. Have you been exposed to Covid-19 in the past 14 days? ☐ Y ☐ N

3. Have you received any vaccine in the past 14 days? ☐ Y ☐ N

4. Have you ever had the Covid-19 vaccine? ☐ Y ☐ N

5. Have you ever tested positive for Covid-19? ☐ Y ☐ N

   - If yes: Date of positive test:_____
     Did you receive monoclonal antibodies or convalescent plasma in treatment of your Covid-19 infection?: ☐ Y ☐ N

6. Are you pregnant or breastfeeding? ☐ Y ☐ N

I am requesting that the Covid-19 antibody test be performed on me. I have had the opportunity to ask questions. I fully release and discharge this pharmacy from any liability for illness, injury, loss and damage. I acknowledge that this is NOT a diagnostic test, and it does not confirm that I currently have a Covid-19 infection, nor does it confirm that I can not get or spread Covid-19. I confirm that the information provided herein is correct and complete to the best of my knowledge and belief.

Signature:_____ Date:_____

Pharmacy use only

Covid-19 IgG/IgM Antibody Test

Lot #:_____ Expiration date:_____ Time started:_____ Time read:_____

Result: IgG: ☐ Positive ☐ Negative IgM: ☐ Positive ☐ Negative ☐ Invalid

Completed by qualified individual? ☐ Provider:_____ Date:_____

☐ If symptoms develop, seek a diagnostic test

☐ If IgM positive, consider a diagnostic test

☐ Continue to practice social distancing and protective face covering