COVID - 19 TESTING

DATE_____TEMPERATURE_____

Name _____Middle Initial _____Date of Birth _____ Age _____ Sex _____

Address _____**County of Residence** _____

Telephone Number _____ Primary CareProvider_____

Occupation _____ Employer or School_____

Emergency Contact _____Relationship_____Telephone Number_____

Ethnicity

____Hispanic or Latino

____Non-Hispanic or Latino

Race

____American Indian or Alaskan Native

____Asian

____Black or African American

____White

____ Native Hawaiian/Pacific Islander

Please Check The Questions That Apply:

_____ Are you 65 years of age or older?
_____ Do you have chronic health conditions?
_____ Do you live in a group home, homeless shelter or assisted living center?
_____ Do you work as a healthcare worker, first responder, EMS, law enforcement, fire, military.
_____ Do you work in a long term care facility or correction facility?
_____ Do you work as a front – line essential worker (grocery store, gas station, etc)?
_____ Have you traveled recently?
_____ Have you been around anyone who has tested positive for COVID – 19?
_____Are you pregnant?
_____ Have you been tested before?

Please Check Your Current Symptoms: This section applies to *ALL AGES*

_____ Fever / Chills **_____ Sore Throat** **_____ Tiredness** **____Diarrhea**
_____ Cough **_____ Loss of Taste or Smell** **_____Headache** **____Other**
_____ Shortness of Breath **_____Nausea &Vomiting** **_____Muscle Aches**
_____Date of symptom onset **_____Hospitalized** **_____ICU**

This Section Applies to *CHILDREN / YOUTH*

_____Abdominal Pain **____ Neck Pain** **_____Rash** **____Red Eyes w/ Drainage** **____ Other**
_____Date of symptom onset **_____Hospitalized** **_____ICU**

FOR STAFF ONLY

TEST INFORMATION

Sophia 2 SARS Antigen FIA RAPID Test* (Quidel Corporation) *Nasal Swab

Ordering Provider _*Dr. Hector Estepan*_____NPI_*1124142369*__CLIA number___*34D2050162*_____

Results: _____ Negative _____Positive Patient Notified_____ Staff_____

West Caldwell Health Council, Inc.

Collettsville Medical Center
4329 Collettsville Rd.
PO Drawer 9
Collettsville, NC 28611

Happy Valley Medical Center
1345 Highway 268
PO Box 319
Patterson, NC 28661

INFORMED CONSENT FOR COVID - 19 TESTING

SARS Antigen FIA (COVID - 19) test is authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA). This test will be performed today with your consent. This test is meant for use in individuals with signs and symptoms compatible with COVID-19 or for individuals with or without symptoms who have been exposed to a person confirmed to have COVID - 19.

- I authorize West Caldwell Health Council, Inc. to perform specimen collection and testing for COVID - 19 through a nasal swab or nasopharyngeal swab, as ordered by a medical provider.
- I authorize my test results to be disclosed to the county, state or to any other governmental entity as recommended or required.
- I authorize my test results to be disclosed to my current employer, college, university, school system, primary care provider, or pediatrician.
- I understand that if my test result for COVID - 19 is negative, I can contract the virus after having the test performed.
- I acknowledge that a positive test result is an indication that I must self - isolate in an effort to avoid infecting others.
- I understand that if I test positive, I will be required to sign a self-isolation agreement.
- I understand that I may need additional care that may require me to go to an emergency room or a hospital if my condition worsens.
- I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur.
- I acknowledge that I can access a copy of West Caldwell Health Council Inc. Notice of Privacy Policy at www.westcaldwellhc.org and that I can receive a written copy upon request.

I have been informed about SARS Antigen FIA (COVID - 19) testing and the procedure process for specimen collection. I have carefully read this consent form in its entirety and been given the opportunity to ask questions before I sign. If I have additional questions after testing, I know how to contact the clinic to seek an answer. I have no additional questions at this time and agree to SARS Antigen FIA (COVID - 19) testing.

Signature/Guardian _____Date _____

Witness _____Date _____

Physician_____

West Caldwell Health Council, Inc.

Collettsville Medical Center
4329 Collettsville Rd.
PO Drawer 9
Collettsville, NC 28611

Happy Valley Medical Center
1345 Highway 268
PO Box 319
Patterson, NC 28661

SELF - ISOLATION AGREEMENT

The Centers for Disease Control and North Carolina Department of Health and Human Services recommends for anyone that is under suspicion for COVID - 19 to be placed in self-isolation to prevent transmission to others. It is important for you to comply with this isolation agreement in order to protect the public's health.

- I understand that I may be infected with COVID - 19 and that I meet criteria for self - isolation.
- I agree that while I wait for my test results, I will self-isolate.
- I agree if my COVID - 19 test results are **positive**, I will remain in isolation for "at least 10 days since symptom onset" **and** until my "symptoms have improved" **and** I am "fever free for 24 hours without the use of fever reducing medications".
- I agree that if my SARS Antigen FIA (COVID - 19) test results are negative, I will remain isolated for at least 72 hours after my symptoms have resolved.
- I understand that if my test result for COVID-19 is negative after known exposure with no present symptoms, I will be asked to quarantine for 14 days after exposure to monitor for symptoms.
- I understand that if I am not self - isolated during my illness, I am potentially infecting others and posing substantial threat to the health of others.
- I agree that I will not come into contact with others while in self-isolation.

I have been educated on self-isolation and have been given the opportunity to ask questions. If I have additional questions after testing, I know how to contact the clinic to seek an answer. I have no additional questions at this time and agree to SARS Antigen FIA (COVID - 19) testing and to self - isolation.

Signature/Guardian _____Date _____

Witness _____Date _____

***In the event that you are not able to stay and wait on your test results, someone will call you with your test results. If you need a printed copy, you may view your test results on your patient portal account. Visit https://westcaldwellhc.org/patient-portal/ and sign-in with your username and password. If you are a new patient, please call 828-754-2409 ext. 154 to set up a patient portal account.**

FOR STAFF ONLY

Ordering Provider **Dr. Estepan**

Test Results _____**Negative** _____**Positive**

Staff Signature _____ **Date** _____