Insurance Information:

Group/Organization:_____ **Location City:** _____

□ **Employee or Member of Group** □ **Family** □ **Re-Test**

COVID-19 Patient Test Request Form

Please complete this form AND provide a copy of patient insurance card and identification at the time of collection.

Patient Information: Completed by Patient or Guardian			
Specimen Collection Date:		**Clinician Name (if applicable):**	
First Name:		Last Name:	
Address:			
City:	State:	Zip Code:	County:
Email (Print Clearly):			
Phone Number:			
Date of Birth:		Age:	Sex: □ Non-Binary □ Male □ Female
Does the patient live or work in a congregate setting (e.g., long-term care facility, shelter, group home, prison) □ **YES** □ **NO**			
Patient Clinical Information			
Date of symptom onset:			
Symptoms Observed: □ None □ Fever □ Tiredness □ Dry Cough □ Body Ache □ Nasal Congestion □ Runny nose □ Loss of smell □ Diarrhea □ Loss of Appetite		Does the patient have any underlying conditions? □ None □ Unknown □ Diabetes □ Hypertension □ Cardiac Disease □ Other □ Immunocompromised □ Pregnant □ Chronic Lung Disease □ Chronic Liver Disease □ Chronic Kidney Disease	
LABORATORY TESTING – Completed by Patient			
Has the patient received Influenza Vaccine? □ **Yes** □ **No**			
Has the patient received COVID-19 Vaccine? □ **Yes** □ **No** **Vaccination Company Name:** _____			
COVID 19 TESTING – Completed by Patient			
Has the patient been tested for COVID-19? □ **Yes** □ **No**		Result: □ **Positive** □ **Negative**	

I hereby acknowledge and give full and complete consent for testing and request:

□ **RT-PCR COVID Swab Test** □ **Anterior Nares Swab (Nostril)**

I hereby acknowledge full and complete consent to and make request for a SARS-Cov2 qPCR and/or IgG. I am physically able to have this nasal swab/blood draw and have never had an adverse reaction to any phlebotomy services. I hereby request and authorize PMH Laboratory, Inc. designated subcontractor who is an independent nurse/ healthcare staffing agency, not directly affiliated with PMH Laboratory, Inc., to collect this sample for me or the person named above for whom I am the legal guardian. I hereby release PMH Laboratory, Inc. its principals, directors, members, employees, affiliates, suppliers, providers, subcontractors, successors, agents, their respective insurance carriers, and the location sponsoring this clinic/program, its principals, directors, employees, affiliates, successors, or agents from any and all liability, injury or damage whatsoever arising from, or in any way connected with, this SARS-CoV-2 qPCR and/or IgG Antibody Test or the administration of same including, but not limited to, acts of negligence. I authorize my medical information herein, including tests results, to be shared with my physician/insurance/employer/school/organization or group. PMH Laboratory, Inc., will use and disclose your personal and health information to treat you, to receive payment for the care we provide, to public health agencies as required, and for our other health care operations which generally include those activities we perform to improve quality care. We have prepared a detailed NOTICE OF PRIVACY AND CONFIDENTIALITY PRACTICES to help you better understand our policies regarding your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. I agree to remain in the general area for at least 5 minutes after collection of samples. Please provide a copy of this form to your physician and/or healthcare provider for your medical records. This test is for informational purposes only and to be discussed with your health care professional. PMH Laboratory, Inc., is not providing you with medical advice nor are they responsible for any outcome in your care or treatment. Please keep in mind that a positive result does not mean you are immune or cannot become re-infected. This test was developed, and its performance characteristics determined by PMH Laboratory, Inc. This test has been FDA cleared or approved. This test has been validated in accordance with the FDA's Guidance Document (Policy for Diagnostics Testing in Laboratories Certified to Perform High Complexity Testing under CLIA prior to Emergency Use Authorization for Coronavirus Disease-2019 during the Public Health Emergency) issued on April 20, 2020. FDA independent review of this validation is pending. This test is only authorized for the duration of time the declaration that circumstances exist justifying the authorization of the emergency use of in vitro diagnostic tests for detection of SARS-CoV-2 virus and/or diagnosis of COVID-19 infection under section 564(b)(1) of the Act, 21 U.S.C. 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.

Patient/Guardian Signature:_____ **DATE:**_____

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CLIA 05D2137011 ◊ STATE CLF351210 ◊ COLA 028736
Rahil R. Khan, MD – Laboratory Director