COVID-19 Testing Demographic and Consent Form

****One Form per Patient****

Reporter Information	
Today's Date:	Testing Location:
Clinician/Nurse Name:	
Do you currently receive medical care at SUIT Health Center? yes no	
Are you a member of SUIT? Yes no	
Patient Name:	Phone Number:
Address:	
DOB:	Gender: male female
How many people reside in the patient's home?	
Does the patient work in a healthcare facility or congregate setting? (long term care; shelter; prison) Yes No If yes, where?	
Does the patient live in a congregate setting? (long term care; shelter; prison) Yes No If yes, where?	
Does the patient receive dialysis? Yes no	
Does the patient work in a dialysis facility? Yes no	

1. I authorize this Covid testing unit to conduct collection and testing for Covid-19 through a nasopharyngeal swab as the collection technique
2. I authorize my results to be disclosed to the Tribe, county, state or to any other government entity as may be required by law
3. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others
4. I understand that if I am not already a patient of the SUIT Health Center that I am not creating a professional relationship with SUIT Health Center by participating in testing. I understand the testing site is not acting as a medical provider. Testing does not replace treatment by my medical provider. 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.
5. I agree that if I am to test positive, I will cooperate with all Tribal and local authorities on any disease investigation deemed necessary.
6. I understand that, as with any medical test, there is a potential for a false positive or false negative result.
7. I acknowledge that I have been given a copy of SUIT Health Center's Notice of Privacy Policy.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

Please carefully read and comply with the following statements:
a. I understand that I may be infected with the virus causing COVID-19 and that I meet criteria for isolation.
b. I agree that while I wait for my COVID-19 test results, I will remain in self-isolation.
c. I agree that if my COVID-19 test results are positive, I will remain isolated for 10 days from this day of testing
d. I agree that if my COVID-19 test results are negative, I will remain isolated until at least 72 hours after my symptoms have resolved.
e. I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons.
f. I agree that I will not come into contact with any other person who is not isolated or ill due to potential COVID19 infection.

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 other questions at any time. I voluntarily agree to testing for COVID-19 and to self-isolation.

_____ _____

Signature of patient/guardian Date

Relationship to patient