PATIENT INFORMATION

1. **Please complete the following information:**
   Patient name_____ Date of birth: _____

   Patient address_____

   Patient county of residence_____

   Patient phone number_____

   Patient occupation_____

   Patient employer _____

2. **Do you live in a group home, assisted living center or other facility with more than 3 other people older than 60 years old?**
   ☐ YES ☐ NO
3. **Do you work in a hospital, long-term care facility or assisted living facility?**
   ☐ YES ☐ NO
4. **Have you traveled anywhere outside of Arizona in the past 1 month?**
   ☐ YES _____ ☐ NO
5. **Have you been in close contact (i.e. within 6 feet) with someone confirmed to have COVID-19?**
   ☐ YES ☐ UNKNOWN

TESTING ELIGIBILITY

COVID-19 diagnostic testing, authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA), will be used today. This test is meant for use in individuals with signs and symptoms compatible with COVID-19.

6. **Please mark the symptoms you are currently experiencing:**

☐ Fever	☐ Muscle aches	☐ Headache
☐ Cough	☐ Nausea and vomiting	☐ Other:
☐ Shortness of breath	☐ Diarrhea	
☐ Tiredness, Fatigue	☐ Sore throat	

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

7. **Please carefully read the following informed consent:**
   a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider or public health official.
   b. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
   c. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
   d. I understand that I am not creating a patient relationship with Banner Health by participating in testing. I understand the testing unit is not acting as my 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.
   e. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.
   f. I acknowledge that I have been given a copy of Banner Health'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.

AGREEMENT FOR SELF-ISOLATION

The local health jurisdiction has determined that if you are under suspicion for having COVID-19 due to symptoms and testing request, that it is necessary to be placed in isolation in order to prevent the transmission of this infection. It is important for you to comply with this Isolation Agreement in order to protect the public's health. Thank you for agreeing to cooperate.

8. 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 **7 days** from this day of testing **OR** until at least **72 hours** after my symptoms have resolved, **whichever is longer.**
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 COVID-19 infection.

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 and to self-isolation.

_____ _____

Signature of patient/guardian Date

_____

Relationship to patient