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COVID-19 TESTING SERVICES

COVID-19 RT-PCR, Antigen & IgG/IgM Test Request Form

TO BE COMPLETED BY COLLECTOR	**PATIENT BILLING INFORMATION: TO BE COMPLETED BY COLLECTOR**
	Please attach a copy of both sides of insurance card & ID Card*
Location: _____	☐ SELF PAY ☐ BILL CLIENT ☐ INSURANCE PPO-HMO*
Collector Name: _____	☐ MEDI/MEDI*:_____ POLICY# _____
D.O.S._____Time: _____	DX Codes _____ _____ _____

PATIENT INFORMATION: TO BE COMPLETED BY PATIENT/GUARDIAN

First Name: MI: Last Name:		
Address:		DOB:
City:	State:	Zip Code:
Sex: ☐ Male ☐ Female ☐ Other	Pregnancy Status: ☐ Not Pregnant ☐ Pregnant ☐ Unknown ☐ Null	
Email (Print Clearly):		
Employee/Student#:		Phone #:

I have been exposed or suspect that I may have been exposed to someone with COVID-19? ☐ YES ☐ NO

Do you live or work in close proximity with other people?(e.g.,a workplace, school, assisted living, group home, prison) ☐ YES ☐ NO

Facility Name: **Employee Occupation:**

RACE/Ethnicity: TO BE COMPLETED BY PATIENT/GUARDIAN

☐ Asian	☐ White	☐ Native Hawaiian/Pacific Islander	☐ Black or African American
☐ Hispanic or Latino	☐ Non-Hispanic or Latino	☐ American Indian or Alaska Native	Other: _____

CLINIC INFORMATION: TO BE COMPLETED BY PATIENT/GUARDIAN

Date of onset Symptoms: / / ☐ None

Does the patient have any underlying conditions? ☐ YES ☐ NO

SYMPTOMS OBSERVED:		**Underlying conditions:**	
☐ Fever	☐ Runny nose	☐ None	☐ Immunocompromised
☐ Tiredness	☐ Loss of smell	☐ Unknown	☐ Pregnant
☐ Dry Cough	☐ Diarrhea	☐ Diabetes	☐ Chronic Lung Disease
☐ Body Ache	☐ Loss of Appetite	☐ Hypertension	☐ Chronic Liver Disease
☐ Nasal Congestion	☐ Other: _____	☐ Cardiac Disease	☐ Chronic Kidney Disease
		☐ Other: _____	

COVID-19 TESTING: TO BE COMPLETED BY PATIENT/GUARDIAN

Has the patient been tested for COVID-19? ☐ YES ☐ NO **Result:** ☐ Positive ☐ Negative

Date: _____ **Test Type:** ☐ RT-PCR ☐ Antigen ☐ Antibody IgG/IgM

LABORATORY TESTING: TO BE COMPLETED BY PATIENT/GUARDIAN

Has the patient been tested for influenza? ☐ YES ☐ NO **Result:** ☐ Positive ☐ Negative **Test Type:** ☐ Rapid ☐ RT-PCR

Has the patient been tested for any other viral respiratory illness? ☐ YES ☐ NO If yes, result: _____

I hereby acknowledge and give full and complete consent for testing and request: ☐ RT-PCR ☐ Antigen ☐ Antibody IgG/IgM

SOURCE: ☐ AN (Anterior Nares) ☐ NP(Nasopharyngeal) ☐ OP(Oropharyngeal) ☐ Blood Serum(SST Tube)

I hereby request and authorize LSA Lab, LLC and its designated subcontractors, who is an independent nurse/healthcare staffing agency not directly affiliated with LSA Lab, LLC to collect this sample for me or the person named above for who I am the legal guardian. In case of the SARS-Cov-2 RT-PCR, Antigen and/or Antibody. I am physically able to have this nasal swab/oral swab collection or blood draw and have never had an adverse reaction to any nurse/phlebotomy services. I agree to remain in the general area for at least 5 minutes after collection of samples. Testing is for informational purposes only and should be discussed with a health care professional. LSA Lab, LLC is not providing you with medical advice nor are they responsible or 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. Please provide a copy of this form to your physician and/healthcare provider for your medical records. I hereby release LSA Lab, LLC its principles, 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 liability, injury or damage whatsoever arising from, or in any way connected with, this SARS-CoV-2 RT-PCR, Antigen and/or Antibody Test or the administration of same including, but not limited to, acts of negligence. I authorize my medical information provided herein, and the test results, to be shared with my physician/insurance/employer. I further consent and authorize to have a designated representative in my employer's/school's HR Benefits department receive a copy of my test results as part of this sponsored COVID-19 testing program. LSA Lab, LLC will use and disclose your personal and health information in order to: treat you, receive payment for the care we provide, provide required disclosures to public health agencies, and 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 CONFIDENTIALTY PRACTICES to help you better understand our policies in regard to your personal health information. I acknowledge that I have received a copy of the Notice of Privacy and Confidentiality Practices. This test was developed, and its performance characteristics determined by LSA Lab, LLC. This test has not been FDA cleared or approved. This test has been authorized by FDA under an Emergency Use Authorization (EUA). 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: _____

ANTIGEN TEST RESULT ONLY COMPLETED BY COLLECTOR

[ ] Antigen Not Detected (**Negative**)

[ ] Antigen Detected(**Positive**)-Recommend self-quartine and evalution by a medical professional.

Name of Collector (Please Print): _____

Manufacturer Name: _____ Lot# _____ Exp. Date_____