RVNA Covid-19 Swab Consent Form

Name of person getting swab	**Gender** ☐ **Male** ☐ **Female**	**Date of Birth**
Address (Street number and street name – no Post Office Box)	**City, State**	**Zip**
Home or Cell Phone **Email**	**Work Phone**	

PRIMARY INSURANCE INFORMATION: Please check your insurance; fill in your insurance ID# and Policy's Holder's name

☐ Aetna
☐ Aetna medicare Advantage
☐ Anthem/Blue Cross
☐ Blue Cross (other than Anthem)
☐ Cigna
☐ ConnectiCare
☐ Medicaid
☐ Medicare Part B
☐ No insurance coverage

Please attach a photocopy of your insurance card to this form.

Insurance ID_____

What is the name of the person who is the Policy Holder?

_____

What is the Policy Holder's date of birth? _____

Relationship to person obtaining swab? Self: ☐ Child: ☐ Spouse: ☐

Primary Care Physician information (for follow up care if needed)

Name of Primary Care Physician _____

Phone number _____

1. Are you experiencing any active symptoms? ○ Yes ○ No
2. Any recent exposure (within last 14 days) to a positive/presumed covid-19 case ? ○ Yes ○ No

I authorize an Oral swab for COVID-19 Test made available through a standing physician's order through RVNA. I further authorize:

1. I am the parent or legal guardian (if the patient is a minor or dependent) of the patient named above.
2. I understand that the RVNA has contracted with Sunrise Medical laboratories for collection of my or my child/dependent's specimen. I authorize RVNA to collect the specimen (via oral swab).
3. RVNA has contracted with Sunrise Medical laboratories for laboratory analysis and report of my, my child's, or dependent's specimen. I authorize Sunrise Medical laboratories to perform testing on my specimen.
4. I understand that processing of the specimen and results may take between 24 to 48 hours.
5. I authorize Sunrise Medical laboratories and/or RVNA to release test results or other information necessary to the DPH.
6. I understand that the physician or authorized healthcare provider identified in this application will be responsible for providing testing results, interpreting test results, explaining testing limitations, and providing any additional diagnostic or clinical services.

By signing below, I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree to hold harmless RVNA and Sunrise Medical laboratories, including its employees, agents, and contractors from any and all liability and claims. I further acknowledge that I understand I will only be notified by RVNA if my test result is positive for COVID19.

Signature: _____ Print Name: _____

STAFF USE ONLY

PCR/Molecular ____ Antigen_____

Administered by: _____ Date___/___/____

Ordering MD_____ fax/phone _____/_____

Print form