**PATIENT COVID SCREENING/CONSENT FORM**
**DIAGNOSTIC TESTING AND HEALTH SCREENING**
**KANAB UNITED DRUG**

Patient Name (print)_____ Date_____

Date of Birth____ /____/_____ Phone: _____Email:_____

Adress:_____City_____State_____Zip_____

Gender: M____F____ Pregnancy Status: Yes___ No____

Ethnicity: Unknown_____Hispanic or Latino_____Not Hispanic or Latino_____Other_____

Race:

____White ____Black/African American ____American Indian

____Alsakan Native ___Native Hawaiian ____Pacific Islander

____Unknown

Drug Allergies:_____

a. I authorize Kanab United Drug to conduct collection and testing for COVID-19 as ordered by an authorized medical provider or health official.
b. I understand, as required by law, my test results will be disclosed to the county, state, or to other government entities.
c. I understand Kanab Drug is not acting as my medical provider, this testing does not replace treatment by my medical provider, and 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.
d. I understand that, as with any medical test there is a potential for a false positive or false negative COVID-19 test result.

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 additional questions at any time and have been given instructions how to obtain a copy of this informed consent. I voluntarily agree to this testing for COVID-19.

Patient Name (print)_____

Patient Signature _____

Representative Name (print)_____

Representative Signature_____

Signature of Witness if verbal consent obtained_____

Primary Care Doctor_____

**CONTINUES ON BACK ---->**

Patient Questionnaire

Do you have any of the following medical conditions?

____Hemoglobin DisorderS ____Severe Heart Condition ____Obesity

____Cancer Treatment ____Kidney Disease that requires dialysis ____HIV

____Moderate/Severe Asthma ____Corticosteroid Treatment ____Diabetes

____Bone Marrow/Organ Transplant ____Immune System Dysfunction

Is this the 1st time you have been tested for COVID-19? _____

Are you employed in a healthcare setting?_____ What is your occupation?_____

Are you experiencing any of the following symptoms?

____Chills ____Shortness of breath ____Nasal discharge

____Vomiting ____Sore throat ____Nausea

____Nasal congestion ____Cough ____Muscle pain

____Loss of sense of taste ____Loss of sense of smell ____Headache

____Fever over 100.4 F ____Feeling feverish ____Fatigue

____Difficulty breathing ____Diarrhea

What date did you start experiencing symptoms?_____

Do you currently live in a congregate setting? If so what type of setting?_____

Method of Payment:

Card number_____ Expiration date:_____ CVV Code_____

FOR OFFICE USE ONLY

____POSITIVE ____NEGATIVE

COMPLETED BY_____