Paradigm Laboratories

Requisition Form for SARS-COV-2 Test

CLIA# 03D2164595
CLIA# 03D2089365
CLIA# 03D2183572
Customer Service 1-888-276-6427
Dr. Wenli Zhou, Ph.D. Laboratory Director

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Tempe, AZ 85281
6117 E. Grant Rd. Tucson, AZ 85712
8222 S 48th St. Ste 190, PHX AZ 85044

ALL INFORMATION MUST BE FILLED OUT OR SAMPLE CAN BE REJECTED. LABELS ARE OK FOR PATIENT AND FACILITY INFORMATION

Patient/Guardian/Physician Signature _____

Date _____

Address _____

Zip Code Resident County _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **D.O.B.:** _____

Phone Number: _____ **Sex:** (M) (F)

Race: [circle one] 1) American Indian 2) Asian 3) Black or African American 4) Native Hawaiian or Other Pacific Islander 5) White

Ethnicity: [circle one] 1) Not Hispanic, Latino, or Spanish Origin 2) Mexican 3) Puerto Rican 4) Cuban 5) Other Hispanic, Latino or Spanish

SPECIMEN INFORMATION

Date of Collection (MM/DD/YY): _____

Time and Date of Collection: _____

FACILITY INFORMATION

Provider Name/address/zip: _____

Specimen Type: _____

READ AND INITIAL EACH STATEMENT BELOW AND SIGN FOR THE SERVICES YOU ARE REQUESTING

☐ I understand that certain patient test results are required by Arizona Administrative Code (R9-4-302 and 404.H. and R9-6-204) to be reported to the Arizona Department of Health Services (AZDHS) for public health reasons. I understand it is my responsibility to consult with my doctor and/or contact my county health department main office.

☐ I am age 18 or older. If <18, I am an emancipated minor or otherwise authorized to request and provide consent for the tests ordered below. If I am requesting testing for which a minor is required by law to consent the minor has consented to such testing.

☐ I understand that Public Law 116-136, 185115[a], the Coronavirus Aid, Relief and Economic Security (CARES) Act, requires "every laboratory that performs or analyzes a test that is intended to detect SARS-CoV-2 or to diagnose a possible case of Covid-19" to report the results from each such test to the Secretary of the Department of Health and Human Services (HHS). I authorize Paradigm Laboratories to release personal testing data to the HHS.

☐ I understand that it is solely my responsibility to promptly discuss all laboratory results with a physician and that neither the laboratories nor its Medical Director will provide interpretation, counseling, consultation, or care recommendations based on any laboratory results provided to me. I release from liability and will not hold the laboratories or their directors responsible if I do not promptly communicate the results of these tests to my physician.

(Required) please Mark the answers below

1. First Covid-19 Test? (Y) (N)
2. Employed in healthcare? Y / N / U
3. Symptomatic as defined by CDC? Y / N / U; if yes, then Date of Symptom Onset (mm/dd/yy) _____
4. Hospitalized? Y / N / U
5. ICU? Y / N / U
6. Resident in a congregate care setting (including nursing homes, residential, care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting): (Y/N/U)
7. Pregnant? Y / N / U

Santa Cruz County Health Services
2150 N. Congress Drive, Suite #204
Nogales, AZ 85621
(520)375-7900
www.santacruzcountyaz.gov

Date: _____

Initial Temperature _____

Temperature Re-Check _____

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

PATIENT INFORMATION

1. **Please complete the following information:**

   Patient Full Name_____ Date of Birth: _____

   Patient Home Address_____

   Patient County of Residence_____

   Patient Phone Number_____

   Patient Cell Phone Number _____

   Patient Occupation_____

   Patient Employer _____

2. **Do you live in a group home OR assisted living center OR long-term care facility OR a personal residence with any other individual over 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 been tested for COVID-19 in the past 30 days?**
   ☐ YES ☐ NO

TESTING DETAILS

_____A COVID-19 reverse transcription polymerase chain reaction (RT-PCR) diagnostic test, authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA), will be used today.

5. **Are you experiencing any symptoms currently?** This will not affect your testing eligibility.

   ☐ YES; please mark which below. ☐ NO

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

6. **Please sign the following attestation: I attest that the information I provided today is correct to the best of my knowledge.**

_____ _____

Patient/Guardian Signature Date

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

7. Please carefully read and sign the following informed consent:

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19, 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 RT-PCR test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
d. I acknowledge that a positive serology test result alone cannot determine if I am acutely infected and that interpretation of the serology test is not yet clearly established.
e. I understand the testing unit is not acting as my medical provider, this 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.
f. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

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.

_____ _____

Patient/Guardian Signature Date

AGREEMENT FOR SELF-ISOLATION

Depending on your current symptoms and test results, the public health recommendations may be to remain isolated. It is important for you to comply with the following Isolation Agreement points in order to protect the public's health. Thank you for agreeing to cooperate.

Please agree to each of the following statements by initialing and signing below.

____ **I agree that if I am *symptomatic* and awaiting COVID-19 test results,** I will stay home away from others or under isolation peculations until results are available. Once results are available I will follow the appropriate recommendations.

____ **I agree that if I am *symptomatic* and tested POSITIVE for COVID-19 by PCR or serology**, I will stay home away from others or under isolation precautions until you have had no fever for at least 3 days (72 hours) without the use of medicine that reduces fevers; AND other symptoms have improved; AND at least 10 days have passed since symptoms first appeared.

____ **I agree that if I am *symptomatic* and tested NEGATIVE for COVID-19 by PCR or serology**, I will stay home away from others for a least 3 days (72 hours) without the use of medicine that reduces fevers AND other symptoms have improved.

____ **I understand that if I am *not symptomatic* and awaiting COVID-19 test results,** I do not require isolation but that I will take everyday precautions to prevent the spread of COVID-19.

____ **I agree that if I am *not symptomatic* and tested POSITIVE for COVID-19 by PCR**, I will stay home away from others or under isolation precautions until 10 days have passed since specimen collection.

____ **I agree that if I am *not symptomatic* and tested POSITIVE for COVID-19 by serology**, I will use a cloth face covering while outside my home for at least 10 days since specimen collection and take everyday precautions to prevent the spread of COVID-19. I also will consider getting a PCR test to help determine if I am currently infected. If I am a healthcare worker or first responder, I will wear a surgical mask or respirator while provide patient care for 10 days after specimen collection.

____ **I agree that if I am *not symptomatic* and tested negative for COVID-19 by PCR or serology**, I do not require isolation but that I will take everyday precautions to prevent the spread of COVID-19.

_____ _____

Patient/Guardian Signature Date

_____

Relationship to Patient