Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

COVID-19 (No Symptoms) Testing to Confirm Negative Status

My Lab ReQuest™
Patient Ordered Lab Tests

Print and bring this completed form with you. This testing is intended for patients that are not experiencing symptoms of COVID-19 but desire testing to confirm negative COVID-19 status. A COVID-19 (No Symptoms - Confirm Negative Status) appointment is required for this testing. If you are experiencing symptoms, please consider our carside appointment and COVID-19 Symptoms/Exposure testing, available on SonoraQuest.com.

Payment Information:

Payment of $115 will be due at time of service.

Laboratory Use Only:

Date Collected ___/___/___	Initials _____	☐ ID Verified ☐ ID Not Provided
Time ___:___	☐ AM ☐ PM	☐ Fasting ☐ Non-Fasting

Step 1: Fill in your demographic info.:

First Name	MI	Last Name	Date of Birth	Sex

Address 1	Address 2	City	State	Zip Code

Phone	Alternate Phone	Email Address	
			☐ **Check to participate in a follow-up survey by email.** (Lab - add code **906559**)

Step 2: Select how you would like to receive your results & optionally provide an alternative contact:

☐ **On-line – the quickest and most secure method available;** through your private and secure account available via SonoraQuest.com (not available for minors) (**Lab-Account 390**)

☐ **Unencrypted email distributed Mon-Fri Only** (Please note, unencrypted information sent via email can be intercepted by unauthorized parties) (**Lab-Account 391**)

Email

☐ I give my permission to discuss my medical information with the person listed below if they contact Sonora Quest Laboratories.

Name **Phone** (**Lab - add code 906558**)

Step 3: Read and initial each statement below and sign for the services you are requesting:

_____ I am requesting Direct Access Testing through My Lab ReQuest. I do not have a physician order for these tests. I understand that only I will receive the testing results. Sonora Quest Laboratories may share the test results with my physician or other providers only in critical or emergent situations or as required by law.

_____ 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. For selected results marked with a on the test menu, a local or state public health investigator may contact me for additional information or to ensure proper treatment. If I receive a positive test result for a sexually transmitted disease or tuberculosis, I understand it is my responsibility to consult with my doctor and/or contact my county health department's STD clinic or 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 (noted by), the minor has consented to such testing.

_____ I understand that Arizona law prohibits laboratories from billing health insurance for patient ordered laboratory testing. I further understand that these tests are not covered by Medicare as Medicare does not cover laboratory testing without a physician order. Full payment is due at time of service.

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

PATIENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

Step 4: The Active Infection COVID-19 testing will be performed based on this completed request. Turn to reverse for next step.

☒ Coronavirus COVID-19 SARS-CoV-2 RNA, Qualitative, NAAT (907080)

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Step 5: Print your name in the box & respond to each item below:

Print Name: (Last, First, Middle)

QUESTIONS AND ATTESTATIONS REQUIRED BY HEALTH AND HUMAN SERVICES AND ARIZONA DEPARTMENT OF HEALTH SERVICES

DO YOU HAVE SYMPTOMS OF CORONAVIRUS? YES ☐ NO ☐

IF YES, DATE OF SYMPTOM ONSET:

IS THIS YOUR FIRST ACTIVE INFECTION TEST? YES ☐ NO ☐

ARE YOU EMPLOYED IN HEALTHCARE? YES ☐ NO ☐

HOSPITALIZED? YES ☐ NO ☐

ICU? YES ☐ NO ☐

DO YOU LIVE IN A CONGREGATE CARE SETTING? YES ☐ NO ☐

ARE YOU PREGNANT? YES ☐ NO ☐ N/A ☐

RACE: WHITE ☐ BLACK OR AFRICAN AMERICAN ☐
NATIVE AMERICAN OR ALASKAN NATIVE ☐
ASIAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐

ETHNICITY: HISPANIC ☐ NON-HISPANIC ☐

Please carefully read the following informed consent: (Your signature at the bottom of this page signifies your agreement)

1. I authorize this COVID-19 testing be conducted through collection or observed self-collection of a nasal swab or other sample type.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I understand the testing facility 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.
4. I understand that, as with any medical test, there is the potential for false positive or false negative test results.

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.

Please carefully read and initial the following agreement for self-isolation: (Your signature at the bottom of this page signifies your agreement)

Please read and initial your agreement to each of the following statements and sign below.

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

☐ I agree that if my COVID-19 test results are **positive** and I develop symptoms, I will remain isolated for 10 days from symptom onset and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms.

☐ I agree that if my COVID-19 test rests are **positive**, but I've never developed symptoms, I will remain isolated and will take appropriate precautions for 10 days from the date of my specimen being collected.

PATIENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

RELATIONSHIP TO PATIENT _____