Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

City of Phoenix

Patient Demographics – A Copy of Your Report Will Be Mailed to You:

Patient Name (Last, First, MI): _____

DOB (MM/DD/YYYY): _____ Patient Sex: M or F

Street Address: _____

City, State & Zip: _____

Phone Number: _____ Relationship to Insured: _____

Insurance Company Name: _____

Insurance ID #: _____ Group #: _____

Insurance Guarantor: _____

Insurance Address: _____

Diagnosis Codes: **Z20.828 / Z11.59**

☐ I am Uninsured:
Social Security or Driver's License Number Required: _____ State:___

Order Information:

Acct #19235 **City of Phoenix**
Arizona Dept of Health Services – COVID-19 (Standing Order Exp 04/22/21)

Cara Christ, MD / NPI 1639369036

Order Test Number/Name: **907080** – SARS-CoV-2 RNA, QL, RT PCR (COVID-19)
SOURCE: Nasopharyngeal

Lab Use Only

Date & Time of Sample Collection: _____

Internal Comments: _____

Note - Send Duplicate Report to Patient

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read and sign the following informed consent:

1. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider or public health official.
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 acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
4. 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.
5. 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.

_____ _____

Signature of patient/guardian Date

AGREEMENT FOR SELF-ISOLATION

The local health jurisdiction has determined that if you are under suspicion for having COVID-19 due to symptoms and testing request, that it is necessary to be placed in isolation in order to prevent the transmission of this infection. It is important for you to comply with this Isolation Agreement 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 understand that I may be infected with the virus causing COVID-19 and that I meet criteria for isolation.
____ I agree that while I wait for my COVID-19 test results, I will remain in self-isolation.
____ I agree that if my COVID-19 test results are **positive**, I will remain isolated for **7 days** from this day of testing **OR** until at least **72 hours** after my symptoms have resolved, **whichever is longer.**
____ I agree that if my COVID-19 test results are **negative**, I will remain isolated until at least **72 hours** after my symptoms have resolved.
____ I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons.
____ I agree that I will not come into contact with any other person who is not isolated or ill due to potential COVID-19 infection.

_____ _____

Signature of patient/guardian Date

_____

Relationship to patient