rxAssist Pharmacy
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COVID-19 POINT OF CARE TESTING PATIENT INTAKE FORM

NAME(Last,First):_____,_____

DATE OF BIRTH: _____.

GENDER:_____

ADDRESS:_____

CITY:_____STATE:_____

ZIPCODE_____ PHONE

NUMBER:_____EMAIL:_____

ADDRESS:_____

RECENT SYMPTOMS:_____

Patient Consent

Patient Name: _____ Date of Birth: _____

I authorize a Rapid Antigen COVID-19 Test as ordered by the authorized healthcare provider, or I am personally requesting to be tested. I further understand, agree, certify, and authorize the following:

1. The patient named above is consenting to the Rapid COVID-19 testing
2. I authorize **rxAssist Pharmacy** to release my results to my employer.
3. **This test has not been Food and Drug cleared or Administration (FDA) approved and has been authorized by FDA under an Emergency Use Authorization (EUA).**
4. **I understand that this test does NOT rule out COVID-19 in ALL COVID-19 Patients. The possibility of a false negative result should be considered in the context of a recent exposures and the presence of clinical signs and symptoms consistent with COVID-19. If COVID-19 is still suspected based on exposure history together with other clinical findings, re-testing or testing with molecular methods should be considered.**
5. I understand this test is for COVID-19 screening purposes ONLY. This screening event is NOT for Medical or life-threatening medical emergencies. This screening event is NOT intended for diagnosis, treatment, recommendation and/or management of ANY medical conditions. This screening event is NOT a substitute for a regular Company or Physician visit
6. I understand that rxAssis will report the results to the relevant state authority.

By signing below I acknowledge that I have read, understand, agree, certify, and/or authorize the information above and further agree to not hold rxAssist Pharmacy, its employees, agents, and contractors from any and all liability and claims.

Signature Patient Name Date

OFFICE USE ONLY : Antigen Test Result: Pos Neg Rph Initials: