_____ RAPID _____PCR **(ATTACH INS. CARD)**

Crawford County Health COVID-19 Order/PUI Form

Name: _____ **DOB:** _____/_____/_____

Parents Name and DOB if Client is a Minor:_____ **DOB:**_____/_____/_____

Local Address: _____ **Sex:** ☐ **Male** ☐ **Female**

City: _____ **State:** _____ **Zip Code:** _____

Phone: (_____) _____-_____

Doctor: _____

COUNTY: _____

Vaccinated: ☐ Yes ☐ No **Exposed to positive case**: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Race:** ☐ White ☐ African American/Black ☐ Native American ☐ Asian/Pacific Islander ☐ Other ☐ Unknown

Pre-Procedure Testing? Positive Results will be released to your physician.

☐ Yes

☐ No INSURANCE:_____(attach copy of card)

First test?
- ☐ Yes
- ☐ No
- ☐ Unknown

Hospitalized?
- ☐ Yes
- ☐ No
- ☐ Unknown

ICU?
- ☐ Yes
- ☐ No
- ☐ Unknown

Congregate Living?
Nursing home, residential care for people with intellectual and developmental disabilities, psychiatric treatment facility, group home, board and care home, homeless shelter, foster care, other:
- ☐ Yes
- ☐ No
- ☐ Unknown

Employed in healthcare?
- ☐ Yes
- ☐ No
- ☐ Unknown

Law Enforcement?
- ☐ Yes
- ☐ No
- ☐ Unknown

EMS/First Responders?
- ☐ Yes
- ☐ No
- ☐ Unknown

Pregnant?
- ☐ Yes
- ☐ No
- ☐ Unknown

Symptomatic as defined by CDC?*
- ☐ Yes
- ☐ No
- ☐ Unknown

Date of Symptom Onset:

_____
mm / dd / yy

***Symptoms:** (check all that apply)
- ☐ Fever or chills
- ☐ Cough
- ☐ Shortness of breath or difficulty breathing
- ☐ Fatigue
- ☐ Muscle or body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea

Collected Date: _____

Collected Time: _____

Source:
- ☐ Nasopharyngeal
- ☐ Nasal
- ☐ _____

THIS PAGE TO BE COMPLETED BY THE NURSE

Test Requested: COVID-19 Ag Card (Rapid Test)

Device: BinaxNOW Ag Card

Facility: Crawford County Health Department
202 N Christopher Boulevard
Robinson, Illinois 62454

CLIA #: 14D888023

Specimen Source: Nasal Swab

SPECIMEN/CARD #_____

Date Test Performed:_____

Time Test Performed:_____

TEST RESULT:_____

Nurse:_____

Called:_____@_____am pm

AUTHORIZATION AND INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read the following informed consent:

I voluntarily consent and authorize Crawford County Health Department (CCHD) to conduct collection, testing and analysis for the purposes of a COVID-19 diagnostic test.

I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample using a NASAL SWAB as ordered by an authorized medical provider or public health official.

I authorize my test results to be disclosed to the county, state or to any other governmental entity as may be required by law.

I acknowledge that a positive test is an indication that I must continue to self-isolate in an effort to avoid infecting others.

I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. 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.

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 RIGHTS AND PRIVACY PRACTICES

Disclosure to Government Authorities: I acknowledge and agree that CCHD may disclose my test results and associated information to appropriate county, state or other governmental and regulatory entities as may be permitted by law.

RELEASE

To the fullest extent permitted by law, I hereby release, discharge and hold harmless, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 test results.

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 carefully read and comply with the following statements:

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 5 days from this day of testing OR until at least 5 days after my symptom's onset **AND**

I agree I will stay on isolation until my symptoms have decreased **AND** I have been fever free for greater than 24 hours.

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.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. By selecting the ACKNOWLEDGEMENT during the registration process for COVID-19 Diagnostic Testing by CCHD, I acknowledge and agree that I have read, understand and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test, and I have been told that I can ask other questions at any time. I understand that if I do not wish to continue with the collection, testing or analysis of a COVID-19 diagnostic test, I may decline. I have read the contents of this form in tis entirety, and I voluntarily consent to undergo diagnostic testing for COVID-19.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN (if patient is under 18) DATE

Relationship to Patient: _____

Client Email/Texting Informed Consent Form

1. Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Email and texts can be used as evidence in court.
g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts

The Crawford County Health Department cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. The Department is not liable for improper disclosure of confidential information that is not caused by the Department's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. The Department cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
d. The Department will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. The Department is not liable for breaches of confidentiality caused by the client or any third party.
g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between the health department and me, and consent to the conditions and instructions outlined.

Client name: _____

Client signature: _____ Date:_____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature: _____ Date: _____

Cell Phone Number: _____

Email Address: _____

Please mark how you would like to be contacted with your results:
_____Text _____Email _____Phone Call

If your result is negative you will be contacted by phone call.