



COVID-19 Free-of-Charge Testing Encounter & Consent Form

Last Name:		First Name:	Middle Name:	Birth Date: ____/____/____
Address: (Not a PO Box)		Street: _____		
		City: _____		State: _____ Zip: _____
Home Phone:		Cell Phone:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Race:	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hawaiian Native or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not Stated			Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and other medical care providers acting on the behalf of the Virginia Department of Health (VDH) to perform a COVID-19 test on me and/or my dependent, as named above. I understand that medical records will be retained for ten years after the date of the last visit, and in the case of a minor, the record will be retained for twenty-eight years after birth. Records will then be destroyed in a manner that assures confidentiality throughout the process and in its results.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.

2. If you should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.

Patient is a close contact to COVID-19 case for ≥ 15 minutes over 24 hours period <input type="checkbox"/> Yes <input type="checkbox"/> No	
Symptomatic: <input type="checkbox"/> Yes <input type="checkbox"/> No IF SYMPTOMATIC CHECK ALL THAT APPLY (Required for Antigen Testing)	
<input type="checkbox"/> Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Fever: Subjective (felt feverish) <u>OR</u> Temperature $\geq 100.4^{\circ}\text{F}$ (38°C)
<input type="checkbox"/> Chills or rigors	<input type="checkbox"/> Headache
<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Fatigue or malaise	<input type="checkbox"/> Runny nose
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Abdominal pain or tenderness	<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Diarrhea (3 or more loose stools/24-hr period)	<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Loss of taste/smell	<input type="checkbox"/> Other: _____

X _____
Signature of Patient, Parent/Legal Guardian Printed Name Date
Relationship (If signature is not of Patient) _____

STAFF USE ONLY

X _____ X _____
Signature of Person Obtaining Consent (Required) Signature of Witness (Needed for verbal consent only)

PCR Testing			Antigen/Point of Care Testing
Lab Corp	DCLS	UVA	
<input type="checkbox"/> L139900 <input type="checkbox"/> NP or <input type="checkbox"/> OP	<input type="checkbox"/> 87252 <input type="checkbox"/> NP or <input type="checkbox"/> OP	<input type="checkbox"/> U0002 <input type="checkbox"/> NP or <input type="checkbox"/> OP	<input type="checkbox"/> BinaxNOW or <input type="checkbox"/> Other _____ <input type="checkbox"/> Nasal Swab or <input type="checkbox"/> Other _____
CODING FOR CE			
Subprogram Code: OC	Diagnosis Code: Z1159 for Asymptomatic	Diagnosis Code: Z20828 for Contact with or Suspected Exposure	

☐ Negative Result – No additional follow-up needed ☐ Negative Result – Follow-up needed (see exception notes)
☐ Positive Result – Follow-up needed (see exception notes)