FIDALAB

☐ **COVID-19** ☐ **Influenza A/B**

PATIENT INFORMATION

It is VERY IMPORTANT to write down your contact information for communication of your test result.

Telephone #: Email:

Last Name: First Name:

DOB: Sex:

☐ Female ☐ Male ☐ Other

Address of Residence: Apt #:

City: State: ZIP:

Race:

☐ American Indian or Alaskan Native ☐ Black or African American

☐ Asian ☐ Native Hawaiian or Other Pacific Islanders

☐ White ☐ Other Race

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

REPORTED SYMPTOMS

☐ Fever, unspecified (R50.9) ☐ Shortness of Breath (R06.02)

☐ Cough (R05) ☐ Others:_____

☐ Exposure to confirmed Covid-19 cases (Z20.828)

SAMPLE INFORMATION

Date of Collection:_____

PATIENT CONSENT

By signing this form, I, the patient having the testing performed, acknowledge that: (i) I have been offered the opportunity to ask questions and discuss with my healthcare provider the benefits, risks and limitations of the test to be performed; (ii) I have discussed with the healthcare provider ordering this test the reliability of positive or negative test results and the level of certainty that a positive test result for a given disease or condition serves as a predictor of that disease or condition; (iii) I have received and read the Patient Informed Consent in its entirety and realize I may retain a copy for my records; (iv) I consent to having this test performed and I will discuss the results and appropriate medical management with my healthcare provider.

X

Patient signature

Date:_____

MEDICAL NECESSITY

I certify that (i) this test is medically necessary. (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and Fida Lab's Patient Informed Consent. I agree to provide Fida Lab, or its designee, any and all additional information reasonably required for this testing to be performed and billed.

X

Healthcare provider signature

Date:_____

Reporting of Covid-19 testing result is mandated under Washington State Administrative Code (WAC) 246-101 (http://app.leg.wa.gov/wac/default.aspx?cite=246-101).