# 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:** ☐M ☐F |
| **Race:** | ☐ American Indian/Alaskan Native ☐Asian ☐Black or African American ☐ Hawaiian Native or Other Pacific Islander ☐White ☐Not Stated | | **Hispanic/Latino:** ☐ Yes ☐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 ☐Yes ☐No | |
|---|---|
| **Symptomatic:** ☐ Yes ☐ No | **IF SYMPTOMATIC CHECK ALL THAT APPLY (Required for Antigen Testing)** |
| ☐ Cough (new onset or worsening of chronic cough) | ☐ Fever: Subjective *(felt feverish)* ***OR*** Temperature ≥100.4°F (38°C) |
| ☐ Chills or rigors | ☐ Headache |
| ☐ Muscle aches | ☐ Sore throat |
| ☐ Fatigue or malaise | ☐ Runny nose |
| ☐ Shortness of breath | ☐ Chest pain |
| ☐ Abdominal pain or tenderness | ☐ Nausea or vomiting |
| ☐ Diarrhea (3 or more loose stools/24-hr period) | ☐ Loss of appetite |
| ☐ Loss of taste/smell | ☐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** | |
| ☐L139900<br>☐NP or ☐OP | ☐87252<br>☐NP or ☐OP | ☐U0002<br>☐NP or ☐OP | ☐BinaxNOW **or** ☐Other________<br>☐Nasal Swab **or** ☐Other__________ |

| CODING FOR CE | | |
|---|---|---|
| **Subprogram Code:**<br>OC | **Diagnosis Code:**<br>Z1159 for Asymptomatic | **Diagnosis Code:**<br>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)**