DHHS
MONTGOMERY COUNTY
Department of Health and Human Services

INFORMED CONSENT FOR COVID-19 TESTING

Name of Individual/Patient _____ Date of Birth _____

Consent for Testing
I verify that I am at least 18 years of age.

I consent to the collection and testing of an oral or nasal swab for the following purpose:

- To see if the sample contains any signs of the coronavirus.

If the individual/patient being tested is a minor. I verify that:

- I am the minor's parent or legal guardian.

As the minor's parent or legal guardian, I consent to the collection and testing of the minor's specimen for the following purpose:

- To see if the sample contains any signs of the coronavirus.

The People Testing You.
The people testing you are not your doctor or medical provider.

I agree that I will:

- Look for medical advice, care and treatment from my healthcare provider if I have questions or concerns
- Look for treatment if I develop symptoms, or if my symptoms change or get worse.

Where Your Tests Will Be Handled.
The Montgomery County Maryland Department of Health and Human Services has designated places to temporarily collect and store test specimens. The County utilizes contracted laboratory services to test the specimens that are collected. All laboratories used for this function are recognized as licensed to perform diagnostic testing for COVID-19 as designated by federal and state regulatory agencies.

I agree to:

- Follow all instructions provided by the specimen collection sites and specimen collection staff.
- Give permission for the designated lab to perform testing on my specimen.

What Kind of Test is This?
Today we will use a test authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA). This test looks for the SARS-CoV2 virus. The SARS-CoV2 virus causes the disease known as COVID-19. This test does not look for any signs that you were infected in the past.
I understand that:

- It is possible that the test may result in a false positive or a false negative.
- Testing is voluntary.
- I may take back my consent at any time before delivery of the test to the lab for testing.
    - I can do this by contacting the Montgomery County Department of Health and Human Services at (240) 777-1755.

Results
Upon completing laboratory analysis of the specimen, the testing lab will make results available to state and local health officials in the jurisdiction you reside as required by law and to the listed referring provider.

I give permission to the Montgomery County Department of Health and Human Services to:

- Contact me using the email address or phone number I provided.
- Send my test results via a secure, encrypted email to the email address I provided.
- Provide me access to my results through a county-maintained or lab-maintained secure web portal.

I understand that:

- I am responsible for checking my email for my results.
- I am responsible for looking at my results when they become available.
- If I receive a positive test result, I may be contacted by a representative of the local or state health department to review the results and explain the next steps I should take.
- I can contact Montgomery County Department of Health and Human Services at (240) 777-1755.

I give permission for my test results to be released to the County, State, or any other governmental entity as may be required by law.

I understand that the results of my test may be released to the Chesapeake Regional Information System for our Patients (CRISP), Maryland's regional health information exchange, which allows my provider to access my test results.

The results of my test will be released to the person or organization that ordered testing.

Cost
Testing services will be provided at no out-of-pocket cost to me.

Privacy & HIPAA Disclosure
The Montgomery County Department of Health and Human Services and its contracted laboratory services comply fully with all laws and regulations regarding privacy, data security, and the Health Insurance Portability & Accountability Act (HIPAA).

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read) and understand the NPP and agree to its terms.

I may see and copy the information described in this form if I ask for it.

I acknowledge that all my questions were answered to my satisfaction, that I fully understand this authorization form.

This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____

Signature of Individual/Patient or Guardian Date

CIAN Diagnostics

Requisition Form – COVID-19 (SARS-CoV-2)

phone: (240) 396-4343, fax: (240) 396-4345, email: info@ciandx.com, website: ciandx.com
5330 Spectrum Drive, Suite I, Frederick MD, 21703
5340 Spectrum Drive Ste. K/H, Frederick MD 21703
Lab Director: Feng Xian, PhD, NRCC
CLIA # 21D2074025

Last Name | **SEX:** ○ Male ○ Female ○ Other

First Name | **DOB:** M M D D Y Y Y Y

Patient Address

City | **State** | **Zip Code**

Ethnicity ○ Hispanic ○ Non-Hispanic ○ Undisclosed **MIDDLE:** | **Phone #:**

Race ○ Asian ○ American Indian ○ Black/African American ○ Islander ○ White ○ Undisclosed

EMAIL:

Uninsured

Clinician Section

Patient assessment: First test? (☐Y☐N☐U) Employed in healthcare? (☐Y☐N☐U) Patient symptomatic? (☐Y:onset date_____☐N☐U)
Patient has been hospitalized? (☐Y☐N☐U) Hospitalized in ICU? (☐Y☐N☐U) Lives in congregate care? (☐Y☐N☐U) Pregnant?(☐Y☐N☐U)

DIAGNOSIS CODE	
☐ R50.9: Fever unspecified	☐ B97.29: Other viral pneumonia
☐ J12.89: Pneumonia COVID 19	☐ Z20.828: Confirmed exposure COVID19
☐ R05: Cough	☐ Z11.5: Special Screen Viral Illness
☐ R06.02: Shortness of Breath	☐ J22: Unspecified Acute Lower Respiratory Infection
☐ Other:	
☐ Other:	

TEST PANEL

☑ COVID-19 (SARS-CoV-2) Test

SPECIMEN COLLECTION

Collection Date: M M D D Y Y Y Y

Collection Time: H H : M M ○ AM ○ PM

☐ Nasopharyngeal ☐ Oropharyngeal ☑ Nasal ☐ Oral

Facility Name DENNIS AVENUE HEALTH CENTER

Facility Address 2000 DENNIS AVENUE

City SILVER SPRING **State** MD **Zip Code** 20902

Phone #: 240 773 1204 **Fax #:** 240 777 4750

Point of Contact MARK ARSENAULT

Clinician Name DR TRAVIS GAYLES **NPI** 1184850653

I hereby authorize Patriot Medical Laboratories DBA CIAN Diagnostics to perform the test panel indicated above. I also understand and hereby acknowledge that the tests ordered herein are medically necessary for this particular patient, given the patient's clinical condition.

Clinician's Signature: Verbal Order | Date:

■ Client consent to testing and delivery of results collected on separate form.