



LIVING WELL
WELLNESS
BETTER HEALTH THROUGH BETTER LIVING

Test Date/Time: _____ Subscriber Name: _____

Patient Name: _____ DOB: _____

Patient Address: _____ Phone: _____

COVID-19 TEST CONSENT

I, _____, authorize and consent to Living Well Wellness to perform a Rapid IgM/IgG COVID-19 test.

I further understand, agree, certify, and authorize the following:

1. I am the parent or legal guardian (if the patient is a minor or dependent) of the patient named above.
2. Living Well Wellness to collect the specimen for the Rapid IgM/IgG COVID-19 test.
3. The Rapid IgM/IgG COVID-19 test has been authorized by the FDA for emergency use.
4. Negative Results do not rule out SARS-CoV-2 infection, particularly in those who have been in contact with the virus. Follow-up testing with a molecular diagnostic should be considered to rule out infection in these individuals.
5. Results from Antibody testing not be used as the sole basis to diagnose or exclude SARS-CoV-2 infection or to inform infection status.
6. Positive results may be due to past or present infection with non-SARS-CoV-2 coronavirus strains, such as coronavirus HKU1, NL63, OC43, or 229E.
7. This Rapid IgM/IgG COVID-19 test is not for the screening of donated blood.
8. My test results will be shared in accordance with federal and state laws for communicable disease control.
9. We may use the results of the Rapid IgM/IgG COVID-19 test for publication without disclosing the patient's identity.

I hereby consent and authorize Living Well Wellness providers as stated above.

Print Patient & Guardian Name Date _____

Patient/Guardian Signature Date _____

Disclaimer: There is a chance that the patient had recent exposure within the last 7 days and the patient did not develop antibodies yet. If that is the case, patient may still be contagious but less likely.

Precautions and Recommendations: Patient is still at risk for future infection if exposed to COVID-19 in the future. If patient become symptomatic, seek medical assistance, retesting may be indicated. Use universal precautions.

Living Well Wellness charges \$75.00 for the Rapid IgM/IgG COVID-19 test.



Patient Name: _____ Date: _____

COVID-19 Rapid IgG Antibodies test is: Negative/Positive

This test detects IgG antibodies that develop in most patients within seven to 10 days after symptoms of COVID-19 begin. IgG antibodies remain in the blood after an infection has passed. These antibodies indicate that you may have had COVID-19 in the recent past and have developed antibodies that may protect you from future infection. It is unknown at this point how much protection antibodies might provide against reinfection.

COVID-19 Rapid IgM Antibodies test is: Negative/Positive

This test detects IgM antibodies. IgM is usually the first antibody produced by the immune system when a virus attacks. A positive IgM test indicates that you may have been infected and that your immune system has started responding to the virus. When IgM is detected you may still be infected, or you may have recently recovered from a COVID-19 infection.

Disclaimer and important information:

- This test has been authorized by the FDA for emergency use, pursuant to Section 564 of the Federal Food, Drug, and Cosmetic Act.
- Negative Results do not preclude acute SARS-CoV-2 infection. If acute infection is suspected, direct treating for SARS-CoV-2 is necessary.
- Results from antibody testing should not be used to diagnose or exclude acute SARS-CoV-2 infection.
- Positive results may be due to past or present infection with non-SARS-CoV-2 coronavirus strains, such as coronavirus HKU1, NL63, OC43, or 229E.
- This test is used for screening purposes only and not for diagnosing of COVID-19, for more definitive answer if you are currently infected and contagious, we highly recommend doing PCR testing by nasal swab for better virus detection.
- Manufacturer had applied for Emergency Use Authorization to the FDA.

Precautions and Recommendations:

- You are still at risk for future infection if exposed to COVID-19 in the future.
- If your symptoms become more symptomatic, then seek medical help.
- Use universal precaution with mask and other protective equipment to reduce the chance of infection and spreading disease.
- Retesting may be indicated if symptoms develop.

Patient Acknowledgment: I understand that the IgG/IgM rapid test has limitations; included but not limited to there is a chance that you have had recent exposure in the last 7-14 days and that you did not develop antibodies yet. If that is the case; you may still have COVID-19 and still be contagious. In order to determine if someone is currently infected with COVID-19, a nasopharyngeal test (PCR) is recommended. The PCR testing is standard for identifying those with active COVID-19. You must speak to your employer for your company policy. We recommend compliance with the current CDC recommendations and this can be found at: www.cdc.gov

Acknowledged by patient: _____

Acknowledged by Nurse: _____



Test Date:
Dates Revised:

COVID-19 PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ Circle Male or Female DOB: _____ Height: _____
Weight: _____ Testing: _____

IgM/IgG for COVID-19 for screening purpose.

- Please abide by CDC guidelines for COVID-19
 - Contact your physician if you develop symptoms including shortness of breath, cough, chest pain, GI symptoms.
- Your COVID testing for screening purpose:

IgG: Negative IgG: Positive so we recommend PCR testing IgM: Negative IgM: Positive so we recommend PCR testing

Your results will be reported to the Health Department as required by law.

You MUST speak to your employer for your company policy. We recommend compliance with the current CDC recommendations and this can be found at: www.cdc.gov

Please contact your physician or hospital with any questions or if your symptoms worsen, please contact the ER, and let them know your COVID-19 results.

Provider Signature: _____

Patient Signature: _____

Living Well Wellness is a privately owned facility. We are not affiliated with any other private/public entity, hospital or government entity.

COVID-19 PATIENT QUESTIONNAIRE

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK YES OR NO

Are you a First Responder or Health Care Professional Fatigue? Yes or No

Shortness of Breath Muscle Pain or Joint Pain? Yes or No

Headache? Yes or No

Diarrhea? Yes or No

Have you been in contact with anyone who has been confirmed to be COVID-19 positive? Yes or No

Are you over the age of 65? Yes or No

Dry Cough? Yes or No

Sore Throat? Yes or No

Chills? Yes or No

Nausea or Vomiting? Yes or No

Nasal Congestion? Yes or No

Recent loss of taste or smell? Yes or No