*Accession/Sample #*_____

CHARLES T. SITRIN HEALTH CARE CENTER, INC.
BINAXNOW COVID-19 Ag CARD
COVID-19 ANTIGEN TESTING CONSENT FORM

Last Name: _____ Suffix: _____
First Name: _____ Middle Initial: _____
Date of birth: _____ Gender:_____ Age:_____
Pregnant or Postpartum (4 weeks)? **Yes** / **No** **ICD:**_____

Residential Address:
Street:_____
City: _____ State: _____
County:_____ Zip:_____
Home Phone: _____ - _____ - _____
Work Phone: _____ - _____ - _____

Local Address (if different from Residential Address):
Street:_____
City: _____ State: _____
County:_____ Zip:_____
Home Phone: _____ - _____ - _____
Work Phone: _____ - _____ - _____

Physician/ Medical Provider Name: _____
Physician/ Medical Provider Phone: _____ - _____ - _____

Occupation
Employer Name:_____Position:_____
Employer Address:_____
Employer Phone Number_____ - _____ - _____

Race (circle one): Black or African- American American Indian or Alaska Native White Asian Native Hawaiian or Other Pacific Islander Unknown Other:_____
Ethnicity: African American Native American/Alaskan Native Pacific Islander, Asian Native Hawaiian White Other:_____

Do you work at **OR** attend a school/college/university? Yes / No
(including elementary, secondary, and post-secondary/higher education)
School Name:_____
School Address:_____
Phone: _____ - _____ - _____
District Name:_____
Basic Educational Data System Code:(BEDS):_____
http://www.p12.nysed.gov/irs/beds/Code%20Manual-2015-16/home.html

First Test? Yes / No
Health Care Employed? Yes / No
Hospitalized? Yes / No
ICU? Yes / No
Congregate Care (Patient/Resident) Yes / No
Symptoms Exhibited? Yes / No Symptoms Onset Date:_____

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I understand and agree that the BinaxNOW COVID-19 Ag Card is used for the qualitative detection of the COVID-19 Antigen. The BinaxNOW™ COVID-19 Ag Card is a lateral flow immunoassay intended for the qualitative detection of nucleocapsid protein antigen from SARS- CoV-2 in direct nasal swabs from individuals suspected of COVID-19. Testing is limited to laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. §263a, that meet the requirements to perform moderate, high or waived complexity tests. This test is authorized for use at the Point of Care (POC), i.e., in Patient care settings operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. The BinaxNOW™ COVID-19 Ag Card does not differentiate between SARS- CoV and SARS-CoV-2.

I have been symptom-free for 14 days. Our goal is to help you determine if you have already had exposure to COVID19. Nasal *pharyngeal* swabs remain the best choice for testing active infections. Testing of antigens during acute illness is not recommended, and you will be asked contact your provider with symptoms of COVID-19 or positive COVID-19 Antigen test results. Coming to us for testing with a recent infection will not inform your diagnosis or treatment.

I understand and agree that the Sitrin Health Care Center will report any *positive* rapid testing results to my health care provider, employer, and the New York State Department of Health within 3 hours via the Electronic Clinical Laboratory Reporting System (ECLRS). Sitrin is required to submit all serology antigen testing (positive, negative, or inconclusive) to the ECLRS four times per day at 5AM-7AM, 11AM-1PM, 4PM-6PM, and 8PM-11PM. False-negative and false-positive results may occur.

I understand and agree that it is best to contact my medical provider/physician to go over any results of all COVID-19 Antigen testing. Positive results indicate the presence of viral antigens, but clinical correlation with Patient history and other diagnostic information is necessary to determine infection status. Positive results do not rule out bacterial infection or co-infection with other viruses. The agent detected may not be the definite cause of disease.

I understand and agree that a negative test does not excuse me from state mandates and social responsibilities. Everyone, regardless of COVID-19 status, should continue to follow rules and regulations regarding social distancing, hand-washing, and wearing face masks. I understand that information about my results (including any identifying data) may be compiled by state and local health department officials. This information may be shared with public health officials and community leaders.

I understand and agree that the risks involved with sample collection can include, but are not limited to, discomfort at the site of the sample collection, possible bruising, redness and swelling around the site, bleeding at the sight and rarely, an infection at the site. Please contact your medical provider if you develop any of these symptoms.

Resident/Patient Signature: _____ Date : _____

Legal Guardian (if under 18/minor)

Guardian Signature: _____ Date : _____

Accession/Test #_____ Start Time:_____ End Time:_____

Result:_____ Clinician Performing Test (Print):_____

Submitted to ECLRS (DATE):_____ By:_____

QA/Tracker logged: YES / NO