Petersburg Medical Center
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Petersburg, AK 99833
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PETERSBURG 2020 ASYMPTOMATIC COVID TEST REQUEST FORM

Expected Date of Test: _____ **For more information visit www.pmcak.org/covid-19**

First Name:_____ MI:___ Last Name:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Phone: (daytime):_____ Evening_____ Email:_____

Date of Birth:_____ Gender:____ SSN:_____

Smokeless Tobacco Status (please check one):

☐ Never chewed tobacco (4) ☐ Never used moist powder tobacco (2) ☐ Chews tobacco (7)
☐ User of moist powder tobacco (6) ☐ Ex-user of moist powder tobacco (3) ☐ Snuff user (5)
☐ Decline (9)

Smoker Status (please check one):

☐ Never smoker (4) ☐ Former smoker (3) ☐ Current every-day smoker (1)
☐ Current some-day smoker (2) ☐ Heavy tobacco smoker (6) ☐ Light tobacco smoker (7)
☐ Decline (9)

Race (please check one):

☐ Asian (A) ☐ White (W) ☐ Pacific Islander/Hawaiian (P) ☐ Multiracial (M)
☐ Black (B) ☐ Hispanic (H) ☐ American Indian/Alaska Native (I) ☐ Other (O) ☐ Decline

Ethnicity (please check one):

☐ Hispanic (H) ☐ Non-Hispanic (N) ☐ Decline (U) (A completed copy of this form is retained by medical records)

CONSENT & RELEASE: I consent to having a nasal swab collected for the purpose of PCR testing for COVID-19. I understand testing will be performed by qualified medical professionals. A negative test result for Covid-19 may indicate you are not infected. You do need to have enough of the virus present for a positive result. If you develop symptoms, please contact your health provider or call the COVID hotline at 772-5788. While waiting for your results, quarantine away from others. You will be contacted by a PMC COVID Hotline nurse with your results. If you do not hear back within three days, please call the hotline.

I understand that the test is not 100% reliable and may, in some cases, indicate a false positive or a false negative. A second test may be recommended under Alaska State Mandates. If there is a positive test result, healthcare practitioners who are directly responsible for my care will be informed of this result so that proper treatment can occur. My identification and results of the tests are confidential and protected against further disclosure to the extent provided by law.

I understand that COVID-19 screening results will be available through **Patient Portal**. Instructions to access this information have been provided to me **today**. I understand that a copy of my results will be included in the PMC EMR (Electronic Medical Records).

☐ I authorize Petersburg Medical Center to send a copy of my test results to the email address designated below:

E-mail Address: _____

I understand that health screening, including "normal values" should not be interpreted as eliminating the need for professional medical care. I further understand that any critical values (those test results requiring immediate attention by the healthcare provider) will be reported to me telephonically at the phone numbers I have provided. **Finally, I understand that I am responsible for getting medical attention if required.**

I will not hold Petersburg Medical Center liable for any incident, act of omission or commission, which arises from heath screening or health education.

I have been informed of my rights to receive the "Notice of Privacy Practices".
☐ I have received a copy of the "Notice of Privacy Practices"

SIGNATURE:_____ **DATE:**_____

A PHOTO ID WILL BE REQUIRED PRIOR TO YOUR COVID-19 TEST