**COVID-19 Test Request Form**

Please complete one form for each patient that COVID-19 testing is requested for. Include form with specimen submission.

**REPORTER INFORMATION**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CLIA Laboratory ID: 19D2217087

Laboratory Director: Xiao-Ming Yin, M.D. Phone: 805-680-0377

**PATIENT INFORMATION**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County/Parish: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other) Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Additional information required for testing:

Does the patient work in a healthcare facility or congregate setting? (e.g., long-term care facility, shelter, prison, jail) ☐ YES ☐ NO If yes, Facility Name & occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient live in a congregate setting? (e.g., long-term care facility, shelter, group home, prison, jail) ☐ YES ☐ NO If yes, Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient pregnant? ☐ YES ☐ NO

**INFORMED CONSENT**

**Please carefully read the following informed consent:**

a. I authorize this COVID-19 testing unit to conduct testing for COVID-19 through a nasal swab

b. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I authorize NanoPin Technologies to email me the results in a HIIPA compliant message.

c. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete responsibility to take appropriate action with regards to my test results.

e. I understand that, as with any medical test, there is the potential for false positive or false negative test results.

f. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

This test was developed, and its performance characteristics determined by NanoPin Technologies, INC. It is intended for the qualitative detection of SARS-CoV-2 in nasal swabs. This test may be used for surveillance, screening or clinical purposes to detect the presence of the nuclear acids of SARS-CoV-2. This laboratory is certified under the Clinical Laboratory Improvement Amendments (CLIA) as qualified to perform high complexity clinical laboratory testing. As a CLIA lab developed test (LDT), this test is not subject to FDA jurisdiction and does not require an Emergency Use Authorization (EUA) from the FDA.

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_