## SLV HEALTH Direct to Consumer Laboratory Testing Services

PARTICIPANT INFORMATION	Preference for Receiving R	esults: Mail	Email 🗌	Pick-up	
		FIRST NAME:			мі: 🗀
DATE OF BIRTH:		# of hours fasted:			MALE
		Emergency Contact Name:			
		<b>Emergency Contact Phone</b>			
MAILING ADDRESS:					
CITY:	STATE:				
					1

## EMAIL ADDRESS:

√ Test	Lab Only	Test Name - Panels	Price			
	DTCCOVPCR	SARS-CoV-2 Test by PCR	\$80.00			
Testing can only be on ASYMPTOMATIC (no symptoms) patients.						
Patients with symptoms should go the SLV Health Respiratory clinic.						
Negative results do not preclude SARS-CoV-2 infection and should not be used as the sole basis for treatment or other patient management decisions. Negative results must be combined with clinical observations, patient history, and epidemiological Information.						
Results are for the detection of SARS-CoV-2 RNA. The SARS-CoV-2 RNA is generally detectable in upper respiratory specimens during the acute phase of infection. Positive results are indicative of active infection with SARS-CoV-2; clinical correlation with patient history and other diagnostic information is necessary to determine patient 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. Laboratories within the United States and its territories are required to report all positive results to the appropriate public health authorities.						

I agree that this test is being requested for the purpose of providing information to me and I understand that no medical interpretation, medical advice, or medical expertise will be provided by SLV HEALTH, Laboratory Director, staff or employees. No doctor-patient relationship exists between the Laboratory Director and me, the requestor of the tests. No doctor-patient relationship exists between the SLV HEALTH staff physicians and me, unless I have specifically scheduled a consultation with a physician who has agreed to accept the responsibility of a formal physician/patient relationship with me.

Participant Signature:

Date: