WH0913LAB
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WAYNE
HEALTHCARE

COVID-19 Antibody Testing Form

Wayne HealthCare • 835 Sweitzer Street • Greenville, Ohio 45331

Name (PLEASE PRINT): ____ Sex: ☐ Female ☐ Male
LAST FIRST MIDDLE INITIAL

Date of Birth: _________/_________/_________ (MUST BE 18 OR OLDER OR HAVE GUARDIAN PRESENT TO PARTICIPATE)
MONTH DAY YEAR

Address: ______________________________________ Home Phone: ____________________

______________________________________ Cell Phone: ____________________

Email Address (REQUIRED FOR PATIENT TEST RESULT PORTAL ACCESS): ______________________________

Emergency Contact and Telephone Number: ______________________________

I hereby grant permission to Wayne HealthCare Laboratory (the "Lab") to perform certain screening tests as set forth below at my direction, which may include obtaining specimens of blood by venipuncture or finger stick. I authorize the Lab to obtain these screening results and mail them to me at the above address. I agree to pay for the tests in full at the time of service.

I understand that the testing has not been ordered by a physician and is being done for my own use and not for medical diagnostic or treatment purposes. Because the tests are not ordered by a physician, insurance coverage is not available, including Medicare or Medicaid. The Lab will not submit the tests to any insurance company for reimbursement.

I further understand that the test results will not be forwarded to any medical professional for diagnosis of any medical condition. It is my responsibility to share the test results with my physician at my sole option. I, alone, am responsible for obtaining medical information, treatment or services from a doctor or other health care provider in relation to the test results.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE ACKNOWLEDGEMENT AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS. BY SIGNING BELOW, I CONSENT TO UNDERGO THE SELF-DIRECTED LABORATORY TESTING UNDER THE CONDITIONS SET FORTH HEREIN.

PANEL	PRICE
☐ COVID-19 Antibody Testing	$65.00

* Fasting Required. Do not eat or drink anything, except water, for 8-12 hours prior to blood collection. Consult your physician before stopping any medications.

TOTAL DUE: $_________ **PAID:** Cash: $_________ Check #: _________ Credit Card: _________ Rec'd By: _________

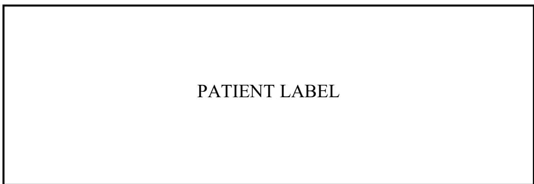
Collection Date: ______/______/______ Collection Time: ______:______ Phleb Initials: ____________

The clarity COVID-19 IgG/IgM Antibody Test is being marketed in accordance with the U.S. Food and Drug Administration's (FDA) recent guidance, titled "Policy for Diagnostic Tests for Coronavirus Disease-2019 during the Public Health Emergency," which was issued on March 16, 2020. The FDA issued this guidance to help accelerate the availability of novel coronavirus (COVID-19) diagnostic tests developed by laboratories and commercial manufacturers during the public health emergency.

- This test has not been reviewed by the FDA;
- 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;
- Results from antibody testing should not be used as the sole basis to diagnose or exclude SARS-CoV-2 infection or to inform infection status;
- Positive results may be due to past or present infection with non-SARS-CoV-2 coronavirus strains, such as coronavirus HKU1, NL63, or 229E.

____
Patient's signature (legal guardian signature if participant is under 18 years of age)

____
Printed name & relationship to patient, if signing on the patient's behalf (Guardian)



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Date