YOU WILL ONLY BE CONTACTED IF YOUR TEST IS POSITIVE.

(PLEASE PRINT CLEARLY)

TESTING DATE: January 18, 2021

Nelsonville, Ohio

Athens City-County Health Department
happy. healthy. prosperous.

_____

First Name *Middle Initial* *Last Name*

_____ _____

Date of Birth *Age*

_____

Street Address *City* *State* *Zip Code*

_____ _____

Phone Number to Receive Results *Email Address*

Why did you do decide to get tested today?

☐ I have symptoms of COVID-19. *(Mark your symptoms below)*

◯ Fatigue	◯ Congestion or Runny Nose	◯ Cough
◯ Sore Throat	◯ Shortness of Breath	◯ Fever
◯ Body Aches	◯ Loss of Taste or Smell	◯ Headache
◯ Diarrhea	◯ Nausea or Vomiting	◯ Chills

☐ I am a contact of someone that has COVID-19.

☐ I am just curious to see if I have COVID-19.

☐ I recently traveled.

☐ I will be traveling in the near future.

☐ I need a negative test result to return to work.

☐ Other: _____

Rev. 12-04-2020

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PLEASE CAREFULLY READ AND SIGN THE FOLLOWING INFORMED CONSENT.

- I authorize this COVID-19 testing unit (Ohio National Guard) to conduct collection and testing for COVID-19 through a nasopharyngeal swab (age 18+) or an anterior nasal swab (age 2-17) as ordered by an authorized medical provider.
- I authorize the testing unit to send my specimen to a participating laboratory for laboratory analysis and report of my, my child's, or dependent's specimen.
- I authorize my test results to be disclosed to local, state, or any other governmental entity as may be required by law.
- I authorize an Athens City-County Health Department staff member to contact me at the number I provided if the result is positive. Positive results for COVID- 19 are reported to the Ohio Department of Health.
- I understand that Athens City-County Health Department will be responsible for providing testing results, interpreting test results, and providing instructions based on my test results.
- I understand that a positive test result is an indication that I must self-isolate to avoid infecting others.
- I understand the testing unit is not acting under my medical provider, and I assume complete and full responsibility to take appropriate action regarding my test result. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns or if my condition worsens.
- I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
- I understand that results are generally available within 48-72 hours but may be longer due to lab volume and processing times.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of the Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this COVID-19 test.

_____

Print Name of Person Receiving Test

_____ _____

Signature of Person Receiving Test or Guardian *Date*

Rev. 12-04-2020

Clinic/Facility Name:	**Athens City-County Health Department**
Account #:	12677
Provider(s):	Dr. James Gaskell
Collection Date:	01-18-2021

MAKO MEDICAL
1 Industry Drive, Henderson, NC 27537
Phone: (252) 572-2795
Fax: (252) 572-4595
CLIA ID: 34D2141858

Clinical Laboratory Improvement Amendments

CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

COVID-19 REQUISITION

1. Patient Demographics

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____ Ethnicity: _____

Address: _____ City/State/Zipcode: _____ Bill To:

☐ Client Bill

Phone #: _____ Email Address: _____

2. Test Selection and Diagnosis Code Selection

☐ **720100 COVID-19 SARS-COV-2 by RT-PCR U0003**

COVID-19 DX CODES

☐ **R05**
Cough

☐ **R50,9**
Fever, unspecified

☐ **Z03.818**
Encounter for observation for suspected exposure to other biological agents ruled out

For cases where there is a concern for possible COVID-19 exposure

☐ **Z20.828**
Contact with and (suspected) exposure to other viral communicable diseases.

Only to be used if actual exposure with someone confirmed to have COVID-19

☐ **R06.02**
Shortness of Breath

☐ **Z11.59**
Encounter for screening for other viral diseases

3 WAYS TO GET YOUR RESULTS:

1. Simply text: MAKO to 66349
2. Go to: https://mako.luminatehealth.com
3. Scan this QR code with your smartphone:

SCAN ME

You get swabbed, sample is collected

Four-Day Test Turnaround

Samples are transported to lab via FedEx or Courier Service	+	Two days are required for the lab to process your sample.	+	One day is needed to generate and upload your results
1 to 2 DAYS		1 to 2 DAYS		1 DAY

=

After 4 days, get your results

If you have not received your test results within four days of collection, please call MAKO.

***NOTE:** Please do not call the lab unless **four full days** have passed.*

Thank you for your patience during this pandemic. Our team is working 24/7 to help thousands of families every day.

I understand that texts sent by Luminate Health are not encrypted and that others who have access to my phone will be able to see my texts.

MAKO MEDICAL

makomedical.com | 919-390-3060