

# Molecular Vision Laboratory Requisition Form for COVID-19 Diagnostic Testing for Travel

1920 NE Stucki Ave, Ste. 150, Hillsboro OR 97006 | P: 503-227-3179 | F: 503-227-3157 | inquiry@mvisionlab.com

## Patient Information

<b>Last Name:</b>	<b>First Name:</b>
<b>DOB:</b>	<b>Email:</b>
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>	<b>Parent Name</b> (if patient is a minor):

## COVID-19 History

**In the last 14 days, have you experienced any COVID-19 symptoms? (Listed below)**  
 Yes  No

**If yes, please indicate which symptoms (Check all that apply)**  
 Fever above 100°F  Chills  Cough, shortness of breath, or difficulty breathing  
 Fatigue  Muscle or body aches  Headache  New loss of taste or smell  
 Sore throat  Congestion or runny nose  Nausea or vomiting  Diarrhea

**Have you been in close contact with a known COVID-19 positive person or someone exhibiting any of the above symptoms?**  Yes  No

## Clinic/Physician Information

<b>Name:</b>
<b>Signature:</b>
<b>Order Date:</b>

## MVL USE ONLY

<b>Sample Type:</b> <input type="checkbox"/> Saliva <input type="checkbox"/> NP swab	<b>Date collected:</b>
	<b>Time collected:</b>
<b>Test collection supervised by:</b> _____ <b>from</b> _____ (initials) (organization)	

# Molecular Vision Laboratory informed consent for COVID-19 testing

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## Patient Consent

### Please carefully read the following informed consent

1. I authorize Molecular Vision Laboratory to conduct diagnostic testing on the sample I have provided for SARS-CoV-2, the virus causing COVID-19.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
4. I understand that I am not creating a patient relationship with Molecular Vision Laboratory by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. 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.
5. I understand that, as with any medical test, there is the potential for false positive or false negative test.
6. I understand that if positive, my sample may be sent to another laboratory to confirm this result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed consent. 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.

\_\_\_\_\_  
Signature of patient/guardian

\_\_\_\_\_  
Date