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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-02658A (10/2020) | **STATE OF WISCONSIN** |
| **COVID-19 TESTING – RESIDENT/PATIENT/CLIENT CONSENT****This form may be used to obtain consent from a resident/patient/client or from the individual’s representative to test for COVID-19.  Use of this form to obtain consent is voluntary.** |
| Coronavirus disease (COVID-19) is an infectious disease caused by a novel (newly discovered) coronavirus. COVID-19 cases have now been reported in all 50 states with many areas having wide-spread community transmission. It is likely that the novel coronavirus is circulating in most communities even if cases have not yet been reported.Most people infected with the novel corona virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems (such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer) are more likely to develop serious illness.People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness, including hospitalization and death.Symptoms may appear **2-14 days after exposure** **to the virus.** Signs and symptoms of COVID-19 include, but are not limited to:* Cough
* Shortness of breath or difficulty breathing
* Fever or chills
* Muscle pain
* Sore throat
* New loss of taste or smell
* Fatigue
* Headache
* Congestion or runny nose
* Nausea or vomiting
* Diarrhea

Given the population served (older adults often with underlying chronic medical conditions), residents/patients/clients are at the highest risk of being affected by COVID-19. If infected with the virus that causes COVID-19, residents/patients/clients are at increased risk of serious illness, hospitalization, and death.Recent experience with outbreaks in long-term care facilities have indicated that residents and staff members infected with COVID-19 may not report typical symptoms, such as fever or respiratory symptoms, and that some may not report any symptoms at all. Unrecognized asymptomatic and pre-symptomatic infections contribute to the spread of the virus in long-term care facilities. |
| **INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING – RESIDENT/PATIENT/CLIENT**  |
| * I have read the attached COVID-19 Fact Sheet regarding testing and authorize testing through a nasal (anterior nasal swab) specimen to be obtained in accordance with the manufacturer’s instruction and guidance from the Wisconsin Division of Public Health.
* I authorize my test results and any follow-up tests to be disclosed to my physician or authorized health care provider, assisted living facility, local/tribal and state public health departments, or to any other governmental entity as required by law.
* I understand that a positive test result is an indication that I am infected with the virus that causes COVID-19 and that I must isolate myself consistent with guidance from the local health department in an effort to avoid infecting others.
* I understand that, as with any medical test, there is the potential for false positive or negative test results to occur.
* I, the undersigned, have been informed about the test purpose, procedure, 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 questions at any time. I voluntarily agree to be tested for COVID-19 and any follow-up testing.
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| **SIGNATURE** – Resident/Patient/Client | **SIGNATURE** – Responsible Party | Date Signed *(MM/dd/yyyy)* |
| **DECLINATION – RESIDENT** |
| I decline COVID-19 testing at this time. The facility/agency has reviewed, and I understand, potential risks of not participating in testing up to and including the possibility of me spreading the virus to others, as well as risk of serious illness, hospitalization, and death. |
| **SIGNATURE** – Resident/Patient/Client | Name – Resident/Patient/Client *(Print or type.)* | Date Signed *(MM/dd/yyyy)* |
| **SIGNATURE** – Responsible Party | Name – Responsible Party *(Print or type.)* | Date Signed *(MM/dd/yyyy)* |