COVID-19 Test Request Form

Please complete one form for each patient that COVID-19 testing is requested for.

REPORTER INFORMATION

Today's Date: _____

Blackbird Clinical Services
2 Executive Drive, Suite D
Lafayette, IN 47905
PH: 765-447-8700 FAX: 765-447-8701

PATIENT INFORMATION

First Name: _____ Last Name: _____ Phone: _____

Address: _____ City: _____

Zip Code: _____ County: _____ State: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ **Male** ☐ **Female**

Additional information **required** for testing:

Are you requesting testing due to job requirements?

☐ **YES** ☐ **NO** Facility Name: _____

Employee Occupation: _____

If you have had recent travel, please list the areas you have visited: _____

Do you have any underlying conditions?

☐ None ☐ Immunocompromised
☐ Unknown ☐ Pregnant
☐ Diabetes ☐ Chronic Lung Disease
☐ Hypertension ☐ Chronic Liver Disease
☐ Cardiac Disease ☐ Chronic Kidney Disease
☐ Other: _____

TEST INFORMATION

This test was developed and its performance characteristics determined by Chemtron Biotech, Inc. This test has not been FDA cleared or approved. This test has been authorized by FDA under an Emergency Use Authorization. This test is only authorized for the duration of authorization of time the declaration that circumstances exist justifying the authorization of the emergency use of indirect immunoassay to detect SARS-CoV-2(COVID-19) IgM/IgG antibodies qualitatively and selectively under section 564 (b) (1) of the Act, 21 U.S.C. 360bbb-3 (b) (1), unless the authorization is terminated or revoked sooner.
When diagnostic testing is negative, the possibility of a false negative result should be considered in the context of a patient's recent exposures and the presence of clinical signs and symptoms consistent with COVID-19. An individual without symptoms of COVID-19 and who is not shedding SARS-CoV-2 virus would expect to have a negative (not detected) result in this assay.
The Rapid test only indicates presence of COVID-19 IgM/IgG antibodies in the specimen or not. It should not be used as the sole criteria for the diagnosis of COVID-19 infection.

PATIENT CONSENT

I have been provided information on COVID-19 testing and understand the limitations of the testing being performed. I have had any questions pertaining to COVID-19 and testing answered. By signing I give my consent to be tested and have the results released to my current employer and/or local health department.

_____ _____
Patient Signature Date

TEST RESULTS

Rapid Testing: IgM Negative_____ Positive_____
IgG Negative_____ Positive_____