

Rapid Covid Testing Centers of Michigan

In partnership with Berkley Urgent Care

SARS-COV-2 Antigen Rapid Screening Test

Name _____ DOB: _____ Age: _____

Phone: _____ Email: _____

Address: _____ Employer (if applicable): _____

City: _____

State: _____ Zip: _____

Rapid Covid-19 Antigen Test Results

Sex:

Male Female

Current Smoker:

Yes No

Pregnant:

Yes No

Ethnicity:

American Indian or Native Alaskan

Asian

Black or African American

Hawaiian or Pacific Islander

White

Not Listed

1. What is the reason for requesting the test?
2. Are you experiencing any symptoms?
3. Have you ever tested positive for SARS-COV-2?

YES NO

If Yes, Date: _____

4. Have you traveled in the past 4 weeks? YES NO

I, _____ (Name of Person Receiving Test or Legal Guardian) authorize Berkley Urgent Care to conduct collection and testing for COVID-19 through a nasopharyngeal swab. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I understand that I am not creating a patient-provider relationship with Berkley Urgent Care by participating in testing. 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 a medical provider if I have any symptoms of COVID-19, questions or concerns. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

Patient/guardian signature: _____

Amount paid today: \$ _____ Cash/Credit/HSA

Employee initials: _____