

COVID-19 PCR Test: Consent and Chain of Custody

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Please carefully read **the following**. If you are **getting a COVID test and are** prepared to provide your consent for the collection and disclosure of personal information as set forth below, sign the following Informed Consent.

- I authorize Avalon Laboratories Inc. ("**Avalon**") to receive, store, and test my swab for COVID-19 as requested by my employer and/or health care provider.
- I authorize Avalon to collect and securely store my personal information for the purposes of patient identification and contact tracing.
- **I understand** Avalon will comply with all **applicable** federal and provincial legislation & regulations governing the protection of personal information and electronic documents.
- I authorize and consent to my test results and personal information including my name, age, date of birth, address and Provincial Healthcare Number to being disclosed to, and retained by, as applicable, the Government of Canada, the Provincial Government in my jurisdiction, the Regional Health Authority, and any other governmental entity as may be required by law (including the Centre for Communicable Disease Control), and to my employer (if applicable).
- I understand Avalon is not acting as my medical service provider or medical practitioner, this testing does not replace treatment by my medical service provider or medical practitioner, and 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 service provider if I have any questions or 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 hereby release Avalon from, and waive, any and all claims, damages, costs, losses and expenses whatsoever that I, my heirs, executors, administrators or estate may have as against Avalon with respect to the specimen collection, storage and testing for COVID-19, and the results thereof.
- **I understand that test results can take up to 48 hours.**

I, the undersigned, hereby confirm I am eighteen years of age or older or that I am the legal parent/guardian of a minor and, have been informed about the test purpose, procedures, possible benefits and risks, and the collection and disclosure of personal information associated therewith. 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 testing for COVID-19 and the collection and disclosure of personal information associated therewith. I certify that I provided this sample to the collector and that the information provided on this form and label is correct. I understand that a positive result will be reported to the appropriate authorities for further investigation and that I may be contacted by them. My consent is considered valid for repeated COVID-19 **testing**, if required. I understand that I may withdraw my consent at any time.

Patient Signature: _____ Date: _____
(An electronically typed name here confirms intent and consent of the patient.)

Ordering Medical Practitioner	Employer/Specimen Information
Name: _____ Phone: _____	Employer Name: _____
Address: _____	Employer Code: _____
X _____ Signature of Ordering Medical Practitioner	Swab Type: <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Nasal + Oropharyngeal
	Media Type: <input type="checkbox"/> Copan eNAT <input type="checkbox"/> SG Medical geneTM

Patient Information	
Patient's <u>Legal</u> Name: _____	_____
<i>Last Name, First Name (as they appear on Government identification)</i>	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth: DD / MONTH / YYYY MCP/PHN/Policy #: _____ (NL / Non-NL Residents)
Email: _____	
Phone: _____	Passport # (if applicable): _____ <input type="checkbox"/> Travelling to Hawaii
Address: _____	

Collection Information	Receipt Information
Collector Name : _____ Code: _____ Phone: _____	Completed by Avalon Laboratories
Collection Address: _____ <input type="checkbox"/> NL collection site _____ <input type="checkbox"/> Outside NL collection site	
Collection Date: DD / MONTH / YYYY Collection Time: _____ (24 hrs)	
I certify that I hold current valid certifications, licenses, or professional qualifications as required by the province to safely carry out swab collection for the test ordered above. The sample collected from the patient identified on this form was collected according to the instructions provided by Avalon Laboratories Inc. The sample was labeled, sealed, and stored appropriately until handed over to Avalon Laboratories Inc.	
Collector Signature: _____ Date: _____	Registered By: _____

For more information, see our privacy policy at www.avalonlaboratories.ca.
If you have a question, concern, or complaint, please contact us at covid@avalonlaboratories.ca