



Mercy Health Lorain  
3700 Kolbe Road  
Lorain, Ohio 44053

Ordering Provider: Malar, Kathleen, CNP

**Patient Name:** \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI)

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:**  M  F

**Race:**  American Indian or Alaska Native (NAAM)  Asian (ASIAN)  
 Black or African American (AFAM)  Hispanic or Latino (HISP)  
 Native Hawaiian or Other Pacific Islander  White (WHITE)  Other \_\_\_\_\_

**Collection** \_\_\_\_\_ **Collection** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time:** \_\_\_\_:\_\_\_\_:\_\_\_\_ **Collector:** \_\_\_\_\_  
(First Initial and Full Last Name)

**Requested Test:**  ACOV (SARS-CoV-2,NAA)

**Specimen Type (check one):**

Anterior Nares (AN) \_\_\_\_\_  
Nasopharyngeal (NP) \_\_\_\_\_  
Oropharyngeal (OP) \_\_\_\_\_

**Questions Required by ODH:**

1. First test (Yes / No / Unknown)
2. Employed in healthcare? (Yes / No / Unknown)
3. Symptomatic as defined by CDC? Yes No
4. Hospitalized? Yes No
5. ICU? Yes No
6. Resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting): (Yes / No / Unknown)
7. Pregnant? (Yes / No / Unknown)

**Collector Instructions:**

- Collect specimen using the provided AN, NP or OP swab with saline media.
- Label media tube with full patient name and date of birth.
- Place labeled media tube with swab into small biohazard bag and seal, place corresponding requisition (this form) in pouch of biohazard bag.

**Lab Use Only:**

- Register in LIS only. EPIC registration not required. Ward: LCLCS

**LORAIN CITY SCHOOLS STUDENT CONSENT FOR COVID-19  
TESTING & AUTHORIZATION/RELEASE FORM**

May we leave a  
message?

Student Name \_\_\_\_\_

Cell Phone \_\_\_\_\_

Y  N  
Initial \_\_\_\_\_

DOB-mm/dd/yyyy \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Emergency contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

1. **Consent for Testing:** I consent to COVID-19 virus testing for the purposes of permitting Lorain City Schools to evaluate whether I am currently infected with the COVID-19 virus.

2. **Release of Information:** I understand that Bon Secours Mercy Health (BSMH) may release medical and/or treatment information regarding my test results to Lorain City Schools. I hereby authorize the use or disclosure of my health information as described in this form, including that my results may be shared with federal/state/local governmental authorities, as permitted or required by law. This authorization shall expire one (1) year from the date of my signature below. I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to BSMH Privacy Officer, 1701 Mercy Health Place, Cincinnati, OH 45237. I understand that a revocation is not effective to the extent that BSMH has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself. I understand that BSMH will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences of me refusing to sign this authorization. I understand there is the potential for information used or disclosed pursuant to this authorization to be subject to re-disclosure by the recipient if the recipient is not required by law to protect the privacy of the information. I understand that I will receive a copy of this authorization if signed by me.

3. **Financial Agreement:** Lorain City Schools will remit payment on my behalf to cover all costs associated with the COVID-19 virus testing.

4. **Certification:** These conditions have been explained to me and I certify that I understand their contents. I further certify that I consent to testing and consent to release of my COVID-19 virus test results to Lorain City Schools and federal/state/local governmental authorities, as permitted or required by law.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person Authorized to Consent \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_  
(If Student is under 18 years of age)

By initialing below, I authorize and consent to receive email message communications to my email address related to my current and/or prospective medical care at the following \_\_\_\_\_  
(email address). Communications may include email messages related to my current and/or prospective medical care as provided by Bon Secours Mercy Health or its affiliates. Additionally, by initialing below, I authorize and consent to email communications related to laboratory outcomes of my COVID-19 test results.  
Communications may come from Bon Secours Mercy Health or its affiliates and/or clinical providers. Standard message and data rates may apply. I may revoke this consent at any time and my consent is not required to receive medical care.

I consent [initials: \_\_\_\_\_]

I do not consent [initials: \_\_\_\_\_]

## COVID-19 Questionnaire

(circle your answer)

COVID-19 has disproportionately impacted people of different ethnicities and age. In an effort to learn more about the virus, state law and CDC research and disease tracking guidelines require us to include the following questions using these specific categories.

1. Is this your first COVID-19 test?

Yes	No	Unknown
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2. Are you employed in healthcare?

Yes	No	Unknown
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3. Are you symptomatic as defined by the CDC?

Yes	No	Unknown
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If yes, Date of Symptom onset:   \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_   (mm/dd/yy)
4. Have you recently been hospitalized?

Yes	No	Unknown
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5. Have you recently been in an ICU?

Yes	No	Unknown
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6. Have you been a resident in a congregate care setting?

Yes	No	Unknown
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(Including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities group homes, board and care homes, homeless shelter, foster care or other setting)
7. Are you pregnant?

Yes	No	Unknown
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8. What is your gender?

Male	Female	Other
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What is your ethnicity/race?

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian and Pacific Islander
- White
- Other