2750 South River Road
Des Plaines Illinois 60018
224/612-7000

Consent for COVID-19 TESTING

________ Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The disease causes respiratory illness (like the flu) with symptoms such as a cough, fever, and in more severe cases, difficulty breathing. COVID-19 is spread through close personal contact or airborne droplets – coughing or sneezing. People may also contact the illness if they touch a surface infected with COVID-19 and then touch their mouths, noses or eyes. There's currently no vaccine to prevent COVID-19.

_________I consent to a RT-PCR COVID-19 validated sputum test. I have been told if the results of this test are positive, my surgery will be cancelled and rescheduled for 4 weeks and a negative COVID-19 test.

By signing below, I confirm that I have read, or have had read to me, and understand the above information. I am of sound mind, under no undue influence and am competent to make this decision and do so of my own free will.

Patient Signature: ____ Date: _______________

Printed Name: ____ Patient DOB:_____________

Relationship: ______________________ Legal Representative Signature: ____________________________

Witness: ____ Date: ______________________

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