



SURGERY CENTER

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 contract 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 a date after I have two negative COVID-19 tests.

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/Time: _____

Legal Representative Signature: _____ Date/Time: _____

Printed Name: _____ Relationship: _____

Witness: _____ Date/Time: _____