



# COVID-19 Rapid Testing Assessment and Consent Form

- I agree to have rapid testing done in the pharmacy today to screen for COVID-19.
- I understand that a swab will be used to collect the sample for the test and that the result will take 15 minutes to become available.
- I understand that rapid testing is less accurate than PCR testing and that there is a small possibility of false-negative results or false-positive results.
- I understand that if the test is positive, that it is likely that I have COVID-19. I understand that I will be asked to report to a public health testing site for immediate PCR COVID-19 testing.
- I understand that a negative result means that my sample did not detect COVID 19 at the time of screening only.
- I understand that if I become symptomatic at any point following my test, I am to refer to public health for the next steps.
- I also confirm that I have not had recent nasal or septal surgery or trauma.

**I confirm the following statements are correct:**

- No severe difficulty breathing (e.g., struggling for each breath, speaking in single words), chest pain, confusion, extreme drowsiness or loss of consciousness
- No shortness of breath at rest or difficulty breathing when lying down
- No new onset or worsening of any of the following symptoms: fever / chills, cough, sore throat / hoarse voice, shortness of breath, loss of taste or smell, vomiting or diarrhea for more than 24 hours
- No new onset of 2 or more of any of the following symptoms: runny nose, muscle aches, fatigue, conjunctivitis (pink eye), headache, skin rash of unknown cause, nausea or loss of appetite
- No close contact in the last 14 days with someone that is confirmed to have COVID-19
- No laboratory exposure while working directly with specimens known to contain COVID-19
- Have not been in a setting in the last 14 days that has been identified by public health as a risk for acquiring COVID-19, such as on a flight, in a workplace or community with a cluster of cases, or at an event.
- Have not received a notification from the COVID Alert app that you may have been exposed to COVID-19
- Have not been advised to quarantine due to any travel outside Manitoba in the last 14 days.

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**Patient name (printed)**

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**Date**

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**Patient Signature**

# COVID-19 Rapid Testing Documentation Form

Test Performed to detect SARS-CoV-2

Patient Name:

Date of Birth:

PHIN:

ID confirmed:

YES

NO

Pharmacist confirmed eligibility of patient:

YES

NO

Patient consent has been completed:

YES

NO

Test Date:

Test Time:

Result Date:

Result Time:

Test Result:

Pharmacist Name:

Licence #:

Pharmacist Signature:

Date:

Pharmacy Information: