wellnesspharmacy
Naz's Pharmacy

Covid-19 Testing Intake and Consent Form

Please fill out this form and email to the pharmacy prior to your appointment.

Patient Information (Name, Date of Birth, and Gender MUST match passport)

First Name: _____ Middle Name(s): _____ Last Name: _____

Date of Birth (DD/MMM/YY): _____ Gender: ☐ Male ☐ Female ☐ X - Another Gender

Telephone Number: _____ Email Address: _____

Care Card Number: _____ Address: _____

Covid-19 Test Information

It is the passenger's responsibility to obtain the required appropriate COVID-19 test in the required timeframe as required by the airline and/or destination.

Type of Covid-19 Test Required: ☐ PCR

Please Answer the Following Questions:

Have you completed and passed the Covid-19 symptoms screening questionnaire?	☐ Yes	☐ No
Have you tested positive for Covid-19 in the last 30 days?	☐ Yes	☐ No
In the past 10 days, have you experienced any of the following: fever, new onset of cough or worsening of chronic cough, new or worsening shortness of breath, new or worsening difficulty breathing, sore throat, runny nose?	☐ Yes	☐ No
Are you requesting a Covid-19 test for travel clearance purposes?	☐ Yes	☐ No
What is your travel destination? (For Hawaii, please ensure you contact your airline for specific requirements.)		
What date and time is your flight departure?	Date (DD/MMM/YY):	Time:

Patient Consent

I consent to having the Wellness/Naz Pharmacy healthcare professional conduct the nasal swab Covid-19 test.
I authorize the pharmacy and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the pharmacy and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I confirm that all of my answers to the Covid-19 screening and other screening questions are true to the best of my knowledge. I acknowledge that if any of the responses are not true, I accept the responsibility that it may affect the accuracy of the test results and/or the validity of the results for travel purposes, and any resulting harm that may be caused.

I acknowledge that if the healthcare professional determines that I am not eligible for a COVID-19 test due to the answers to the screening questions or other clinical reasons, I will agree with the recommendation to not receive a COVID-19 test.

I acknowledge that it is my responsibility to obtain the required appropriate COVID-19 test in the required timeframe as required by my airline and/or destination. I acknowledge that it is not the responsibility of Wellness Pharmacy Group. I acknowledge that the timing of the test result is an estimate and is not a guarantee. I understand that the COVID-19 tests are not 100% accurate. As such, I acknowledge that Wellness Pharmacy Group will not be held liable for any financial or other costs I may incur if I am not allowed to board my flight or am denied entry into my connecting or final destination as a result of the COVID-19 PCR or antibody test collected or facilitated by the pharmacy or the travel certificate provided by the pharmacy.

☐ I am providing consent for myself ☐ I am providing consent for the patient identified above

Name of person providing consent (and relationship to patient if applicable): _____

Signature: _____ Date (DD/MMM/YY): _____

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Healthcare Professional Use Only	
Type of Covid-19 test given: ☐ PCR	
Lot #:	Expiry Date:
Date of Test (DD/MMM/YY):	Time of Test:
Reason for Test: ☐ Travel clearance	☐ Other:

I confirm that the patient/agent named above is capable of providing consent. I confirm that the Covid-19 test should be provided to the patient based on my assessment.

Name of Healthcare Professional Administering Test: _____

License #: _____ Signature: _____