

# COVID-19 TESTING – RESIDENT CONSENT TO TEST AND RELEASE OF RESULTS

Due to presence of COVID in long term care settings, Governor Walz has directed that all individuals who reside and work in nursing homes and assisted living settings be offered testing for COVID-19.

Each Nursing Home and Assisted Living is required to maintain documentation and verification that testing has been completed, including documentation related to any refusals to test by residents and staff.

## CONSENT FOR CORONAVIRUS (COVID-19) TESTING AND RELEASE OF RESULTS

- I have read the attached COVID-19 Fact Sheet and consent to initial and follow up testing with a nasal or oral specimen to be obtained in accordance with the manufacturer’s instruction and guidance from the Minnesota Department of Health.
- I have had an opportunity to review [general information on COVID-19](#) and ask questions and received answers to my satisfaction.
- I have been informed about the test purpose, procedure, benefits, and risks, and I have received a copy of this informed consent.
- By my signature below, I voluntarily agree to be tested for COVID-19 including follow-up testing that may be required.
- I authorize my test results to be disclosed to the county and state public health departments or to any other governmental entity as may be required by law.
- I understand that, as with any medical test, there is the potential for false positive or negative test results to occur.

<b>SIGNATURE</b> – Resident	Name – Resident ( <i>Print or type</i> )	Date Signed ( <i>mm/dd/yyyy</i> )
-----------------------------	--	-----------------------------------

<b>Verbal Consent:</b> Name of Person Giving Consent: _____ Phone # _____ Relationship to Resident: _____ Nurse Taking Verbal Consent: _____ Title _____	Date Signed ( <i>mm/dd/yyyy</i> )
---	-----------------------------------

## DECLINATION – RESIDENT

I decline COVID-19 testing at this time. The facility has reviewed, and I understand, potential risks of not participating in baseline testing up to and including hospitalization and/ or death and may affect my ability to work until I am tested.

<b>SIGNATURE</b> – Resident	Name – Resident ( <i>Print or type</i> )	Date Signed ( <i>mm/dd/yyyy</i> )
-----------------------------	--	-----------------------------------

<b>Verbal Consent:</b> Name of Person Declining Testing: _____ Phone # _____ Relationship to Resident: _____ Nurse Taking Verbal Declination: _____ Title _____	Date Signed ( <i>mm/dd/yyyy</i> )
--	-----------------------------------