Riley's Drugs
1207 W. Main Street
Lexington SC 29072
803-359-2587

PATIENT TESTING CONSENT FORM

Name: ______________________________ Date of birth: ______________________

Address: ______________________________ City: ______________________

County: ____________________ State:________ Zip code: ____________ Last 5 digits of SSN: ________

Phone number: ________________________ Gender: ☐ Male ☐ Female Pregnant: Y / N

Allergies: ____________________ Pre-existing Diseases/Conditions: ______________________

Primary care provider name: ____________________ Phone: ______________________

How would you best describe your race? Please select all that apply. If you would prefer not to answer this question, you may leave it blank.

☐ American Indian or Alaskan Native
☐ Black or African American
☐ Other race
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ White

Have you had a direct exposure to COVID-19 or Flu? ☐ Yes ☐ No ☐ Unsure

Approximately how many days ago were you exposed? ______________________

What symptoms are you experiencing now? Please select all that apply.

☐ Fever or chills
☐ Muscle or body aches
☐ Congestion or runny nose
☐ Cough
☐ Headache
☐ Nausea or vomiting
☐ Shortness of breath
☐ New loss of taste or smell
☐ Diarrhea
☐ Fatigue
☐ Sore throat/Hoarseness
☐ No symptoms

For how many days have you been experiencing symptoms? ______________________

Do you work in a healthcare setting? Y / N Do you live in a long term care facility? Y / N

By signing the line below, I give consent to Riley's Drugs to send my testing results to the South Carolina Department of Health and Environmental Control (DHEC).

Patient signature: ______________________________ Date: ______________

--FOR STAFF USE ONLY --

Car make/ model/ color ________________ Credit card #: ____________________ Exp: ________

Type of test: ☐ COVID-19 Rapid Antigen ☐ COVID-19 Antibody ☐ Influenza A & B

Lot # ____________ Exp: ______________ Result: ______________________

Date Administered ____________ Time Tested ____________ Time Read ____________

Administered by ______________ Signature ______________________ License # ____________