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| **DEPARTMENT OF HEALTH SERVICES** Division of Quality Assurance  F-02658 (09/2020) | | **STATE OF WISCONSIN** | |
| **COVID-19 TESTING – STAFF CONSENT** **This form may be used to obtain consent from staff to test for COVID-19.**  **Use of this form to obtain consent is voluntary.** | | | |
| Coronavirus disease (COVID-19) is an infectious disease caused by a novel (newly discovered) coronavirus. COVID-19 cases have now been reported in all 50 states with many areas having wide-spread community transmission. It is likely that the novel coronavirus is circulating in most communities even if cases have not yet been reported. Most people infected with the novel coronavirus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems (such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer) are more likely to develop serious illness.  People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness including hospitalization and death.  Symptoms may appear **2-14 days after exposure** **to the virus.**  Signs and symptoms of COVID-19 include, but are not limited to:   * Cough * Shortness of breath or difficulty breathing * Fever or chills * Muscle pain * Sore throat * New loss of taste or smell * Fatigue * Headache * Congestion or runny nose * Nausea or vomiting * Diarrhea   Given the population served (older adults often with underlying chronic medical conditions), staff having close contact with residents/patients/clients and infectious materials are at high risk of becoming infected with the virus that causes COVID-19. Staff who become infected with the virus are at increased risk of serious illness, hospitalization, and death.  Recent experience with outbreaks in long term care facilities have indicated that residents and staff infected with COVID-19 may not report typical symptoms such as fever or respiratory symptoms and some may not report any symptoms at all. Unrecognized asymptomatic and pre-symptomatic infections contribute to the spread of the virus in long term care facilities. | | | |
| **INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING – STAFF** | | | |
| * I have read the attached COVID-19 Fact Sheet regarding testing and authorize testing in accordance with the manufacturer’s instruction and guidance from the Wisconsin Division of Public Health. * I authorize the disclosure of my test results and any follow-up test results to the county and state public health departments or to any other governmental entity as required by law, the ordering provider, or my employer. * I understand that a positive test result is an indication that I am infected with the virus that causes COVID-19 and I must isolate myself consistent with guidance from the local and state health departments in an effort to avoid infecting others. * I understand that, as with any medical test, there is the potential for false positive or negative test results to occur. I understand if I have any unusual symptoms after testing, it is my responsibility to seek medical attention. * I, the undersigned, have been informed about the test purpose, procedure, benefits, and risks, and I have received a copy of this informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask questions at any time. I voluntarily agree to be tested for COVID-19, including any follow-up testing. | | | |
| **SIGNATURE** – Staff | Name – Staff *(Print or type.)* | | Date Signed *(MM/dd/yyyy)* |
| **DECLINATION – STAFF** | | | |
| I decline COVID-19 testing at this time. The facility/agency has reviewed, and I understand, potential risks of not participating in testing up to and including the possibility of me spreading the virus to others as well as risk of serious illness, hospitalization, and death. | | | |
| **SIGNATURE** – Staff | Name – Staff *(Print or type.)* | | Date Signed *(MM/dd/yyyy)* |