ASH Pharmacy COVID-19 Testing Form

Patient Information

Name:_____ Date of Birth:_____
Street:_____
City:_____ State:_____ Zip:_____
Patient ID_____ Gender: M or F
Email address: _____

	Yes	No	Don't Know
Are you sick today?			
Have you been hospitalized in the past 3 days for Covid related symptoms?			
Have you been contact with any person with symptoms of Covid-19 in the last 3 days?			

Terms and Conditions:
I agree to the fact that it may take between 24 to 72 hours to get test results from the lab
I agree that ASH Pharmacy is not responsible for any delays in getting your lab results
I acknowledge that ASH Pharmacy is not responsible for your inability to travel and that you are solely responsible for meeting your travel requirements.
All fees paid for Covid-19 testing are Non-Refundable under any circumstances

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient