Questionnaire and Consent form for COVID-19 Test

(Date month day year)

Name **Patient ID**

Date of birth: **month** **day** **year** **Body temperature** **℃**

【Questionnaire】 Please circle ○ [yes] or [no] for the following questions:

1 Have you been in contact with a person infected (or is suspected of being infected) with COVID-19 without taking appropriate precautionary measures within the last 2 weeks?
Yes ・ No

2 Do you have symptoms such as cough, shortness of breath, fever, chills (ague), muscle pain, sore throat, or impaired sense of taste or smell?
Yes ・ No
If you answered yes, please describe the symptoms and date (period) of onset:
(Since:) (Symptoms:)

3 Have you traveled outside of Japan within the last 2 weeks? Yes ・ No
(Since:) (Country:)
Some conditions and symptoms may be eligible for treatment using health insurance.

Before taking a test please note:

COVID-19 infection may not always manifest symptoms.
In very rare cases, a positive result of the antigen test may be obtained even though there is no coronavirus in the body.
A positive result may occur even if there are no symptoms, and the Infectious Diseases Control Law may require you to register as an asymptomatic carrier depending on the content of the test.
If infection is determined, the law requires isolation or other appropriate measures, so please follow instructions of your local public health center (hokenjo).
If you take the antigen test, please consider the possibility of testing positive. Take standard precautions against infection and refrain from non-essential outings until the result comes out.

I understand the above information, and I agree to take the antigen test for SARS-CoV-2.

Signature

Travel Clinic, Center Hospital of the National Center for Global Health and Medicine