OFFICIAL USE ONLY:

DATE OF TEST:_____/_____/_____

TIME OF TEST:_____:_____ AM / PM

RESULT DELIVERY PREFERENCE:
EMAIL ☐ PICK-UP ☑
AUTHORIZED _____
JAPAN CERTIFICATE NEEDED ☐

TEST RESULTS
DETECTED ☐ NOT DETECTED ☐
RESULTS DELIVERED ☐ SCANNED ☐

TESTKIT #:_____
COBAS-LIAT ROCHE (STAT) ☐

AMERICAN MEDICAL CENTER
Your Partner in Healthcare

PCR / ANTIGEN TESTING FOR TRAVEL CLEARANCE
PATIENT INTAKE FORM

CONTACT INFORMATION

(PLEASE FILL OUT THE FOLLOWING INFORMATION, AS IT APPEARS ON YOUR PASSPORT):

LAST NAME: _____ FIRST NAME: _____

DOB: _____/_____/_____ GENDER: _____
mm dd yyyy

NATIONALITY: _____ PASSPORT #: _____

EMAIL: _____

PHONE: _____

(FOR VISITORS)

HOTEL: _____ ROOM #: _____

(FOR LOCALS)

HOME ADDRESS: _____

TRAVEL INFORMATION

DATE OF DEPARTURE (LEAVING GUAM): _____/_____/_____
mm dd yyyy

TIME OF DEPARTURE: _____:_____AM / PM DESTINATION: _____

(FOR THOSE TRAVELING TO JAPAN ONLY): DO YOU REQUIRE *A JAPAN MINISTRY OF HEALTH: CERTIFICATE OF TESTING FOR COVID-19* IN ADDITION TO YOUR TEST RESULT DOCUMENT?

YES ☐ NO ☐ N/A ☐

CONSENT

I authorize American Medical Center to perform all necessary steps associated with COVID-19 diagnostic testing, including collection, testing, processing, and analysis of my sample. I understand that a designated healthcare professional will perform a collection procedure such as a nasopharyngeal or oral swab in order to procure a viable sample for COVID-19 diagnostic testing. I consent to undergoing measures of COVID-19 diagnostic testing, as deemed appropriate by the healthcare professional. In the case of a positive test result, I agree to take appropriate action in compliance with the policies and guidelines set forth by local and federal health authorities. Should the condition of my health worsen, I assume complete and full responsibility to seek advice and treatment from a medical provider immediately. I acknowledge and accept that there are risks and benefits associated with undergoing COVID-19 diagnostic testing, including the possibility of receiving a false-positive or false-negative result. I hereby release, discharge, and hold harmless American Medical Center and affiliated parties from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results, to the fullest extent permitted by law.

PRINTED PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE SIGNED: _____/_____/_____
mm dd yyyy

OFFICIAL USE ONLY:

NOTES: