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INFORMED CONSENT FORM FOR CARRYING OUT THE ANTIGEN TEST (NASOPHARYNGEAL SWAB) FOR COVID 19-Ag-RDTs.

The patient *

Last and first name	
Date of birth (DD/MM/YYYY)	
Place of birth	
Fiscal code	
Phone number	

Or: for the patient indicated above, the undersigned*

Last and first name			
Date of birth (DD/MM/YYYY)			
Place of birth		Fis. code	
Phone number			

As the:

☐ parent ☐ caregiver ☐ legal guardian ☐ (other)

(*) Contact details are required to access the test

INFORMATION FOR INDIVIDUALS WHO EXPRESS CONSENT TO UNDERGO AN ANTIGEN TEST (NASOPHARYNGEAL SWAB) FOR COVID 19-Ag-RDTs

The individual who undergoes testing must be aware of the meaning of the test outcome and the consequent actions.
The outcomes specifications and requirements of the test are as outlined below:

✔ Adherence to the test is considered integral at all stages of the diagnostic process;
✔ A positive test result involves a period of fiduciary self-isolation by the person concerned, until a

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negative test is obtained;

✔ The outcome of the test will be communicated to the relevant Regional sanitary institution (ATS);

✔ In event of doubtful test outcome, the person concerned will follow the same procedure as provided for a positive test result;

✔ The antigen testing is performed using a nasopharyngeal swab.

I, the undersigned, have read and understood the aforementioned information, and I voluntarily provide my informed consent to carry out antigen test (nasopharyngeal swab testing) for surveillance Covid-19 – Ag-RDTs and to follow the consequent procedures in the event of doubtful or positive test result.

Date _____ **Signature _____**

I also declare that I have received and taken note of the information referred to in Article 13 of Regulation 679/2016 / EU "General Data Protection Regulation".

Date_____ **Signature_____**

Signature of the Operator who performed the test and read the outcome **_____**