Patient Consent for Strep Throat Testing (Rapid Antigen Detection Test)

Sirocco Pharmacy: Strep Throat Screening Consent Form

Patient Name: _____ DOB: _____ Health Care Number: _____ Date: _____

Procedure Information

A Rapid Antigen Detection Test (RADT) for Group A *Streptococcus* (Strep Throat) involves taking a swab of the back of the throat and tonsils. The results are typically available within 10–15 minutes.

Important Considerations

- **Accuracy:** While highly specific, a rapid test can occasionally yield a "false negative." If symptoms are severe or persistent despite a negative result, a follow-up throat culture or physician consultation may be necessary.
- **Carrier Status:** A positive result indicates the presence of Strep bacteria, but in rare cases, a person may be a "carrier" while the current sore throat is caused by a virus.
- **Privacy:** Your results will be documented in your pharmacy record. If a prescription is required, the pharmacist will document the assessment and may notify your primary care physician.

Patient/Guardian Consent

- I authorize the pharmacist at **Sirocco Pharmacy** to perform a throat swab for the purpose of testing for Group A *Streptococcus*.
- I have had the opportunity to ask questions and understand the risks and benefits of the test.
- I understand that the pharmacist will provide me with a copy of the results and, if positive, will discuss treatment options which may include a prescription if appropriate under the pharmacist's scope of practice.

Signature: _____ Date: _____ *(Patient or Authorized Representative)*

Pharmacist Use Only

- **Symptoms Reported:** ☐ Sore Throat ☐ Fever ☐ Absence of Cough ☐ Swollen Lymph Nodes
- **Test Result:** ☐ Positive ☐ Negative
- **Action Taken:** ☐ Prescription Issued ☐ Referred to Physician ☐ Supportive Care Advised

Pharmacist Name/Initial: _____