1. All reasonable efforts should be made to obtain informed consent or informed refusal. Often refusals are a function of a communication or information gap. For example, some patients may have an underlying fear of the nasopharyngeal swab, but anterior nares or mid-turbinate samples could be offered instead.

2. If patient makes an informed refusal, they have a right to do so. The implications for the patient of their refusal (such as time to don PPE in an emergency resuscitation may lead to worse outcome, healthcare worker PPE utilization, etc.) should be included in the informed consent/refusal process.

3. If there is concern that in spite of the clinician's best efforts, the refusal is not an informed one, the teams could call an ethics consult (x16230) or another third party (such as chaplain service) to discuss.
1. If patient were SARS-CoV-2 positive, would the procedure/intervention/care proceed? If so, then it should proceed even if there is an informed refusal of SARS-CoV-2 testing.
   a. Emergency/urgent procedure in PUI
   b. Non-urgent procedure/admission in a low prevalence area, patient screens negative, has been sheltering in place, etc.
2. If SARS-CoV-2 positive status would lead to a delay out of the best interest of the patient, then a patient refusal to test would indicate a delay.
   a. In the setting of low prevalence in the community, the likelihood of an asymptomatic patient testing positive is low. When probability is sufficiently low, weigh the risks and benefits of patient being positive.
   b. Increased utilization of PPE is an insufficient reason to deny treatment alone. In the setting of resource scarcity, some care may be delayed (such as less urgent surgeries/admissions)