COVID-19 TESTING QUESTIONNAIRE

ALL THE INFORMATION ON THIS FORM IS CONFIDENTIAL

Why are you requesting a test today? _____

Name: _____
Last Name, First Name

Date of Birth: _____ **Age:** _____ **Sex assigned at birth:** ☐ Male ☐ Female

Tel: _____
(xxx) xxx-xxxx

Mailing Address: _____
Street or PO BOX City, State Zip Code

How would you like to receive your results? ☐ Mail (3-5 bus. days) ☐ Wait on-site

Are you a healthcare worker? ☐ Yes ☐ No **Do you live or work in a congregate setting?** ☐ Yes ☐ No

Are you a tribal member? ☐ Yes ☐ No **Are you pregnant or postpartum?** ☐ Yes ☐ No

Have you been tested in the last 365 days? ☐ Yes ☐ No

Symptoms: ☐ **No symptoms**

☐ Cough	☐ Fatigue	☐ Feeling feverish	☐ Muscle pain
☐ Fever >= 100.3F	☐ Headache	☐ Chills	☐ Loss of sense of taste
☐ Shortness of Breath	☐ Diarrhea	☐ Difficulty breathing	☐ Loss of sense of smell
☐ Nausea	☐ Vomiting	☐ Sore throat	☐ Nasal congestion
Date symptom(s) began: _____ ☐ **Unknown**			☐ Nasal discharge

Vaccination Status: ☐ Fully Vaccinated ☐ Partially Vaccinated (1 Dose of Moderna/Pfizer) ☐ Not Vaccinated

If fully vaccinated, has it been at least 14 days since your last vaccination? ☐ Yes ☐ No

By signing this consent form I acknowledge that:

- I consent to receiving a test for COVID-19
- If the person receiving the test is a minor, I have the legal authority to consent on behalf of the child/minor.
- I authorize leaving my results in a voicemail message on the number I wrote above: Yes ____ No ____
  Initial Initial

_____ _____
Signature of patient/ representative Date

_____ _____ _____
Printed Name of person who signed above Relationship to patient Date of birth

FOR OFFICE USE ONLY				
Test Type:		Result:		Contacted:
ID NOW PCR	ABBOTT RAPID ANTIGEN	POSTIVE	NEGATIVE	Call: ___/___ Email: ___/___ Mail: ___/___ On-site: ___/___ _____ _____ _____ _____ INITIALS INITIALS INITIALS INITIALS