

COVID-19 TESTING - PATIENT INTAKE FORM

Effective August 1, 2020 section 18115 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law 116-136) requires all clinical laboratories to report demographic data on each individual tested for COVID-19. Failure to report COVID-19 test results along with demographic data may result in revocation of a laboratory's clinical lab permit. We appreciate your compliance with this new regulation.

DEMOGRAPHIC INFORMATION

| LAST NAME: _ | | FIRST NAME: | MIDDLE NAME: |
|--------------|--|---------------|--------------|
| ADDRESS: | | | |
| CITY: | | STATE: | ZIP CODE: |
| COUNTY: | | PHONE NUMBER: | |
| RACE: | | | |
| | ASIAN AMERICAN INDIAN OR ALASKA NATIVE NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER OTHER | | ! |
| ETHNICITY: | LUCDANIC OD LATINO | | |
| | HISPANIC OR LATINO NOT HISPANIC OR LATI DECLINED | INO | |
| | UNAVAILABLE/UNKNOV | VN | |

Healthcare providers can answer the following questions on behalf of the individual tested for COVID-19:

| TEST QUESTION | ANSWER OPTIONS | NOTE/DETAILS |
|--|----------------|---|
| First Test? | Yes No Unknown | Is the patient being tested for COVID-19 for the first time? |
| Employed in Healthcare? | Yes No Unknown | Clinicians, Clinic/Hospital Staff, First Responders, Caregivers, etc. |
| Symptomatic as defined by the CDC? | Yes No Unknown | CDC Symptoms: Fever/chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste or smell, congestion/runny nose, sore throat, nausea/vomiting, diarrhea. |
| Date of Onset: | Date: | |
| Hospitalized? | Yes No Unknown | Is this patient currently admitted to a hospital? |
| ICU? | Yes No Unknown | Is this patient currently admitted to an ICU? |
| Resident in a congregate care setting? | Yes No Unknown | Including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting. |
| Pregnant? | Yes No Unknown | |
| Pre-Procedure/Pre-Operation? | Yes No Unknown | Is this patient scheduled for a procedure/operation in the near future? |
| Date of procedure/operation: | Date: | |