COVID-19 Testing Questionnaire - ADULT

Name (Last, First): _____ **DOB**:_____

Cell Phone :_____ **Email** : _____ **Zip Code:** _____

Do we have permission to text your results? ☐ Yes ☐ No If yes, will send to phone number listed above.

If your family comes to Tosa Pediatrics for routine care, do you have the same insurance as your child? _____ **Yes** _____ No _____ N/A

Full name of child at the practice (if applicable): _____

I understand that if my insurance is different from that of my child, I must provide my personal insurance. I understand that if my insurance does not cover the cost of the COVID-19 test, that I am responsible for any balance. If I am a WSD staff member, I understand that it is my responsibility to forward any balance to the WSD Human Resources Department otherwise I will be held responsible for the charges. I understand that COVID-19 is a reportable disease such that testing information including name and results will be forwarded to my local health department and possibly my school/district nurse. I authorize the staff at Tosa Pediatrics to leave a voicemail or text at the number above with any test results.

Signature _____ **Date**_____

Please answer the following questions. If the questions are unclear, please ask your healthcare provider.

1. Have you been exposed to anyone who tested positive for COVID-19 OR is waiting for test results? _____ Yes _____ No _____Unsure
   If yes, when was your last exposure? _____ days ago

2. Do you or did you have any of the following symptoms?
   - ☐ Fever or Chills
   - ☐ Fatigue
   - ☐ Muscle or body aches
   - ☐ Nausea or vomiting
   - ☐ Cough
   - ☐ Sore throat
   - ☐ Diarrhea
   - ☐ New loss of taste or smell
   - ☐ Shortness of breath/ difficulty breathing
   - ☐ Congestion or runny nose
   - ☐ Headache

   If yes, when did they first start? _____

3. Are you pregnant? _____ Yes _____ No

4. Are you fully vaccinated for COVID-19? _____ Yes _____ No

5. Have you tested positive for COVID-19 in the last 90 days? _____ Yes _____ No
   If yes, what is the date of the positive test? _____

6. Ethnicity: Hispanic or Latino: ☐ Yes ☐ No ☐ Unknown ☐ Decline to Answer

7. Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Black/Trinidadian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other ☐ Decline to Answer

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Office use:

Temp _____ F Pertinent findings:_____

Test sent to: TP WDL TPL RN/MA Signature: _____ Date: _____

Result: _____ POS _____Neg Notified of result, isolation guidelines (if indicated): _____

Entered into database: ☐ Reported to state: ☐ Init:_____Date: _____

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