

COVID-19 Testing Questionnaire - ADULT



Name (Last, First): _____ Maiden Name (if appl): _____

DOB: _____ Date: _____ Cell Phone: _____

Address: _____ City _____ State _____ Zip _____

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

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.

- 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
- Do you currently have any symptoms? _____ Yes _____ No _____ Unsure
If yes, when did they first start? _____ Please list symptoms: _____
- Are you on staff or a teacher at a school(s) or daycare? _____ Yes _____ No
If yes, what school/daycare? _____ Grade/Room _____
- Are you pregnant? _____ Yes _____ No
- Are you a healthcare worker? _____ Yes _____ No
- In the last 3 years, have you received a service for *yourself* at Tosa Pediatrics, such as COVID testing or an influenza vaccine? _____ Yes _____ No
- Ethnicity (circle): Hispanic or Latino: Yes / No Decline to Answer Unknown
- Race (circle): American Indian/Alaskan Native Asian Black/African American White Unknown
Native Hawaiiin/Pacific Islander Other Decline to Answer

Office use:

Temp _____ F Pertinent findings: _____

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

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

Entered into database: _____ Init: _____ Date: _____