



COVID-19 Testing Questionnaire - ADULT

Name (Last, First): _____ DOB: _____

Cell Phone : _____ Email : _____

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): _____

Do you want your results emailed? Yes No If yes, will send to email listed above.

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 Cough Shortness of breath/ difficulty breathing
 Fatigue Sore throat Congestion or runny nose
 Muscle or body aches Diarrhea Headache
 Nausea or vomiting New loss of taste or smell

If yes, when did they first start? _____

3. Are you on staff or a teacher at a school(s) or daycare? _____ Yes _____ No

4. If yes, what school/daycare? _____ Grade/Room _____

5. Are you pregnant? _____ Yes _____ No

6. Are you a healthcare worker? _____ Yes _____ No

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

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

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

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: If positive, faxed: Reported to state: Init: _____ Date: _____