COVID-19 TESTING – PATIENT INTAKE

*** Please be thorough and write legibly ***

Last Name _____ First Name _____ MI _____ DOB _____ SSN _____

Address _____ City _____ State _____ Zip _____ County _____

I have already set up a *Patient Portal* account ☐ **Yes** ☐ **No** **(if unanswered, your portal will be reset)**

Sex
- ☐ Male
- ☐ Female
- ☐ Other

Race
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Islander
- ☐ Declined
- ☐ Unavailable/Unknown

Ethnicity
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino
- ☐ Declined
- ☐ Unavailable/Unknown

Person responsible for receiving results:

Full Name _____ **DOB** _____

Phone _____

Email _____

*** Email is required if you wish to use the *Patient Portal***

☐ Check here if you are the parent/guardian/spouse of the person being tested and want him/her to appear in your portal.

TEST QUESTION	ANSWER OPTIONS	NOTE / DETAILS
Vaccinated? If Yes to Vaccinated	☐ Yes ☐ No Doses ☐ 1 ☐ 2 ☐ Moderna ☐ Pfizer ☐ J & J	Have you received any form of the COVID-19 Vaccine
First Test?	☐ Yes ☐ No ☐ Unknown	Is the patient being tested for COVID-19 for the first time?
Known Exposure?	☐ Yes ☐ No ☐ Unknown	Has the patient been notified of being around a known COVID-19 outbreak?
Employed in Healthcare?	☐ Yes ☐ No ☐ Unknown	Clinicians, Clinic/Hospital Staff, First Responders, Caregivers, etc.
Symptomatic as defined by the CDC?	☐ Yes ☐ No ☐ Unknown If yes, **check** all the symptoms that apply in the next box.	CDC Symptoms (**Check** all that apply): ☐ 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**
Onset date of symptoms:	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:	

Patient Consent / Authorization

I hereby authorize the release of medical information related to this service of submission of personalized reports to my healthcare providers, insurance carriers, and Florida Department of Health. This information provided on this form is accurate. I hereby assign to the laboratory my right to insurance benefits that maybe payable to me for the services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility for all charges whether or not they are covered by my insurance.

Insurance / Payment Info.

Primary Insurance Name: _____
Subscriber Name: _____ DOB _____
Policy #: _____ Subscriber Relationship _____
Secondary Insurance Name: _____
Subscriber Name: _____ DOB _____
Policy #: _____ Subscriber Relationship _____

Patient / Parent / Guardian: ➡ Date: ➡

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.

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