

Patient Information			
Patient Name (Last):	(First):	(M.I.):	Birth Date:
Social Security Number:			
Patient Address (Street):	(City):	(State):	County:
(ZIP):			Patient Phone Number:
Contact Email Address:			Patient Sex: (Please circle one)
			Male or Female
Patient Race:	<input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		Patient Ethnicity:
	<input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Patient type:	<input type="checkbox"/> Staff <input type="checkbox"/> Household member <input type="checkbox"/> Student		School:
Name of person at school:			
Questions for Entry			
Is this your first Test?	Y or N or Unknown	Symptomatic as defined by CDC?	Y or N or Unknown
		If yes, date of onset: _____	
Employed in healthcare?	Y or N or Unknown	Pregnant?	Y or N or Unknown
Was patient hospitalized due to condition?	Y or N or Unknown	Was patient admitted to ICU for condition of interest?	Y or N or Unknown
Resident in a congregate care setting (including nursing homes, residential care, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care, or other setting)? Y or N or Unknown			

Consent to be tested for COVID-19:
 I have turned in my consent form.

To be completed by person performing specimen collection:	
Laboratory Testing: <input type="checkbox"/> SARS-CoV-2 (COVID-19) NAA (RT-PCR)	Diagnosis Code: <input type="checkbox"/> Z20.822
<input type="checkbox"/> SARS-CoV-2 Rapid Antigen Test	
Collection Location: <input type="checkbox"/> Saliva <input type="checkbox"/> Oral <input type="checkbox"/> Nasal	
Collection Date:	Collection Time: Collector Initials:
Signature of Provider, Collector or Health Official: _____ Date: _____	