Covid-19 Test

Montgomery County Department of Health (MCDH)

Patient Information Sheet

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please complete information below Medical Provider

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| --- |
| **PATIENT INFORMATION** |
| First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_ Age:\_\_\_\_ Sex: □ Male □ Female Race: \_\_\_\_\_\_\_\_ □Hispanic □Non-Hispanic  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have : □ NO INSURANCE □MEDICAID ID NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □OTHER  Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Insured on Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **CLINICAL INFORMATION** |
| **Do you have symptoms: □YES □NO If symptomatic, onset date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Please check symptoms below you are experiencing or leave blank if no symptoms/asymptomatic**  **□ Fever >100.4 F □Chills □Muscle Aches □Runny Nose □Sore throat □Cough □Headaches**  **□Shortness of breath □Nausea or Vomiting □Abdominal Pain □Diarrhea >3 loose stools in a day**  **Other symptoms not listed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? Only check the ones you have: |
| I have pre-existing medical conditions: □YES □NO  □Chronic Lung Disease (asthma/emphysema/COPD □Diabetes Mellitus □Cardiovascular Disease  □Chronic Renal Disease □Chronic Liver Disease □Immunocompromised Condition □Current Smoker  □Neurologic/Neurodevelopmental Condition □Former Smoker □If female, currently pregnant  □Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| History/Additional Information required for testing |
| Do you work in a health care facility or congregate setting? (e.g. long term care, prison, jail)  □YES □NO If yes, Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Did you work while ill? □YES □No Last Day of work:\_\_\_\_/\_\_\_/\_\_\_  Do you live in a congregate setting? □YES □NO If yes, facility name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you a close contact of a known positive COVID case? □YES □NO |
| I attest and voluntarily consent to the following:  □ COVID-19 testing  □ Release of my medical information to process my insurance claim.  □ Reviewed the “Notice of Privacy Practices” for MCDH @ [www.montgomerycountync.com](http://www.montgomerycountync.com)  □ Received “Coronavirus Disease 2019 Guidance for Persons Under Investigation”  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date |
| For Health Department Use Only  Specimens for COVID -19 Testing: Specimen #\_\_\_\_\_\_\_\_ Date of Specimen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specimen Type: □NP □OP Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sent to: □State Lab □Quest □\_\_\_\_\_\_\_\_\_\_\_\_  Specimen Collected by: □ Amy Taylor, MLT Nurse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |