COVID-19 TESTING FORM

PATIENT NAME: _____

STREET ADDRESS: _____(City) _____(State) _____(Zip)

MAILING ADDRESS: _____(City) _____(State)_____(Zip)

Cell Phone: (___) ____-_____

Date of Birth (MM/DD/YYYY): ____/____/_____ Age:_____ Gender:_____

CONSENT FOR TREATMENT/ HIPAA RELEASE

I hereby consent for treatment as determined necessary by the provider. I authorize the release of information as necessary for continuity of care, for insurance billing purposes, and for collection attempts. I also agree and understand that as a recipient of care at this testing event, if I am not utilizing the free voucher system, that I am ultimately financially responsible for expenses incurred for treatment received.

Signature: _____ **Date:** _____

This testing is being done as a service to the people of Teton County. No patient physician relationship is established by this testing. Should you require examination or treatment, you will need to register with Emerg+A+Care or with any other provider of your choice.

1. Do you have Blue Cross Blue Shield of Wyoming, First Choice of the Midwest (look for logo on your card), Medicaid of Wyoming, Medicare?
    - ❑ Yes
    - ❑ No

Insured persons only:

Name on insurance card:_____ Date of Birth: _____

Insurance Card Number: _____

We will also take a picture of your insurance card at the event.

FILLED OUT BY ALL WHO WANT TO BE TESTED:

2. Do you have symptoms? If no, skip to question #6.

❑ Yes
❑ No

3. Symptoms: (check all that apply)

❑ Fever > 100.4
❑ Feeling feverish
❑ Cough
❑ Shortness of Breath
❑ muscle aches
❑ sore throat
❑ runny nose
❑ nausea or vomiting
❑ headache
❑ abdominal pain
❑ diarrhea
❑ asymptomatic
❑ other , Please specify:_____

4. (If you have symptoms / are symptomatic) When did your symptoms begin?: _____

5. Do you have another reason for feeling ill?
❑ Yes if yes, then what is the reason for your illness?_____
❑ No

6. In the past 14 days, did you travel?
❑ Yes if yes, where?_____ when?_____
❑ No

7. Are you a healthcare worker providing direct patient care?
❑ Yes
❑ No

8. Did you have close contact with a laboratory confirmed case of COVID-19 in the past 14 days?
❑ Yes
❑ No

9. Do you have continued close contact with persons age 65+ or those with underlying health risks (diabetes, heart disease, lung disease, immunocompromised), i.e. are you a caregiver?
❑ Yes
❑ No

10. Please list any pre-existing medical conditions:

_____

_____

FOR STAFF USE ONLY/Submitter Information:

Ordering Provider: Brent Blue, MD
Submitter Name (please list your facility/clinic name): Emerg-a-care
Submitter Address: (Street/City/State/Zip): 455 E. Broadway Jackson, WY 83001

Submitter Telephone Number: (307)733-8002

Submitter Fax Number: (307)733-0032

Specimen Collection Date: 5/28/2020

Specimen type:
❑ Nasopharyngeal Swab (required)

Test Requested:
❑ COVID-19

LAB TO BE SENT TO:

❑ WYOMING PUBLIC HEALTH LABORATORY

❑ LABCORP