CWFM COVID-19 DRIVE THRU DEMOGRAPHICS

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_ \_ Sex: M / F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_ \_\_\_\_\_\_\_\_

City: \_\_\_ \_\_\_\_\_\_\_\_\_\_ State: \_\_ \_\_ Zipcode: Phone number: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Doctor/PA/FNP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did you complete your telehealth visit today? YES NO

Circle the test you are having today. **Rapid Covid/Flu** (same day)  **PCR** (send out 24-48hour) **Strep**

* Is this your first Covid-19 test? YES NO
* If no, have you ever had a positive? YES NO
  + If YES, when was your first positive? \_\_\_\_\_\_\_\_\_\_\_\_
* Are you employed in healthcare? YES NO
* Are you symptomatic as defined by the Center for Disease Control (CDC)? YES NO
  + Fever Cough Shortness of breath Sore throat
  + If yes when did your symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you ever been hospitalized with Covid-19? YES NO
* If yes, were you in ICU? YES NO
* Have you had close contact with a person known to be positive for COVID? YES NO
  + If YES, what was the date of exposure? ­
* Are you a resident in congregate care setting (nursing home, group home, psychiatric treatment facility, or foster care)? YES NO

By signing this form and consenting to testing, you are giving Conroe Willis Family Medicine consent to treat your healthcare needs according to Covid-19 results.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or legal guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR OFFICE USE ONLY:**

DATE OF SERVICE: OPERATOR:

**RAPID COVID-19/FLU**

COVID: positive negative

FLU A: positive negative

FLU B: positive negative

STREP: positive negative

Alliance\_\_\_\_\_\_\_\_\_\_\_ Quest\_\_\_\_\_\_\_\_\_\_\_