COVID-19 Testing Site - Intake Form

Name:_____ Date of Birth:_____

Address (mailing)_____ Gender: _____ Pregnant? ☐ Yes ☐ No

Phone:_____ Email Address: _____

Primary Doctor / Clinic:_____ ☐ No Primary Care Provider

Insurance Name:_____ Insurance ID # _____

Do you work for Olympic Medical Center? ☐ Yes ☐ No

Do you live in a Skilled Care Facility? ☐ Yes ☐ No

Do you have a job that involves direct patient contact? ☐ Yes ☐ No

REASON FOR TESTING (Choose ONE):

☐ **Pre-Op Testing: Date of procedure:** _____

☐ **OMC Provider**

☐ **Outside Provider:**_____ **Reason for Procedure:**_____

☐ **Symptoms (see side 2), no known exposure***

☐ **Exposure*, if symptoms see side 2**

When_____ (testing should not occur less than 3 days after exposure)

Exposure means you have had close contact with a person diagnosed with Covid-19 (close contact means living with or spent more than 15 minutes within 6 feet of the person) *Clallam County Health Department recommends testing occur 3 to 5 days after exposure

SYMPTOMS (check all that apply)

☐ Fever (**over 100.4F?** ☐ Yes ☐ No)
☐ Chills
☐ Cough
☐ Sore Throat
☐ Shortness of Breath
☐ OTHER:
_____

☐ Fatigue
☐ Headache
☐ Diarrhea
☐ Runny Nose or Congestion
☐ Muscle/Body Aches
☐ New Loss of Taste or Smell
☐ Nausea or Vomiting

By my signature below, I am consenting to COVID-19 testing. I understand my insurance may be billed for this service, but that there will be no out of pocket expense for me. I understand that I may request a copy of the complete Consent for Treatment and Financial Responsibility, Patient Rights & Responsibilities, as well as the Notice of Privacy Practices.

Signature of Patient or Patient's Authorized Representative:_____ **Date:**_____

(If under 17, adult must sign)

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