COVID-19 DRIVE THROUGH TESTING: SCREENING QUESTIONNAIRE

Date initial screening completed: _____

Intake Screener: _____

NOTE: Emergency warning signs for COVID-19 get medical attention immediately.

- **Difficulty breathing**
- **Persistent pain or pressure in the chest**
- **New confusion or inability to arouse**
- **Bluish lips or face**

*****This list is not all inclusive. Please call 911 if an emergency or medical provider, or public health nurse for any other symptoms that are concerning*****

After interview information:

Qualified for Test: □ Yes □ No

Ascession/ID #: _____

Time/Date scheduled for specimen collection: _____

Location: Skamania County Community Health

Front Office Checklist:

Emailed forms when indicated: □

Created Credible Profile: □

Scanned forms into Credible: □

PERSONAL INFORMATION

1. Name: _____

2. Date of birth: _____ **Male** □ **Female** □

3. Phone Number: _____

4. Email: _____

5. What is your primary language? _____

6. Do you have special needs in any of the following areas?
□ Reading/Vision □ Hearing □ Mobility (e.g., wheelchair, walker, etc.) □ Translator

7. Employer: _____

Position: _____

8. Do you work within the following groups (such as healthcare workers (hospitals/clinics), police officers, department of corrections, fire fighters, EMS, emergency responders, grocery store workers, other critical services, etc.)? □ Yes □ No

_____ Health Care Worker _____ First responders/Law Enforcement

_____ Grocery/pharmacy _____ Other critical services

NOTE: Further information regarding priority groups is within the "COVID Standing Order".

9. These tests are being conducted with laboratories, do you give verbal consent for us to provide your information to Quest Diagnostics, Center for Disease Detection or the Washington State Public Health Lab in order to process your information to perform the test? □ Yes □ No

SYMPTOMS SCREENING

10. Are you currently experiencing a fever or have you had a fever within the last 72 hours?

□ Yes □ No **Temp.:** _____

If yes, what date did your fever start? _____

If yes, and no current fever, what date did you last experience this symptom? _____

11. Do you currently have a cough or have you had a cough within the last 72 hours?

□ Yes □ No

If yes, what date did your cough start? _____

If yes, and no current cough, what date did you last experience this symptom? _____

12. Do you currently have shortness of breath or have you experienced shortness of breath within the last 72 hours □ Yes □ No

If yes, what date did you start experiencing shortness of breath? _____

If yes, and no current shortness of breath, what date did you last experience this symptom? _____

13. Do you currently have any chest discomfort? □ Yes □ No

14. Have you experienced in the last 72 hours or are you currently experiencing symptoms like □ muscle aches □fatigue □loss of appetite □sore throat □runny nose

15. Have you experienced in the last 72 hours or are you experiencing *mild symptoms* like □sore throat □nasal congestion □ nausea □vomiting □diarrhea □headache

16. Are you immunocompromised? □ Yes □ No

17. Are you older than 60 years of age? □ Yes □ No

18. Are you pregnant? □ Yes □ No

19. Has your medical provider recommended that you get tested? □ Yes □ No

Who is your primary care provider? _____

20. Do you have any other symptoms? □ Yes □ No **If yes, what symptoms:**

_____

21. Does anyone in your household have COVID-19 symptoms and is waiting for a test result from a COVID-19 Test? □ Yes □ No

INFORMATION TO GATHER IF PERSON WILL BE TESTED FOR COVID-19

22. Social Security Number: _____

23. Physical Address: _____

24. Mailing Address, if different: _____

25. Do you have private insurance/Medicare or Medicaid? □ Yes □ No

26. If so, I'll need your PRIMARY insurance/Medicare or Medicaid information

Name of Insurance Carrier _____

Insurance carrier (Who is the insurance under)? _____

Group Number _____

Insurance/CMS Number _____

27. Do you have a SECONDARY insurance company? _____

Insurance carrier (Who is the insurance under)? _____

Group Number _____

Insurance ID Number _____

Insurance company phone number _____

28. Emergency Contact Name _____

Phone Number _____ **Relationship** _____

29. Race: Alaska Native □ American Indian □ Asian □ Black □ Native Hawaiian □

Pacific Islander □ White □ Unknown □

30. Ethnicity: Hispanic □ Non-Hispanic □

31. Consent Form/Instruction sheet Emailed? □ Yes □ No

Email: _____

32. If your result is negative, can we leave a detailed message with the results on your phone? Yes □ No □

33. "I understand that if I have symptoms of COVID-19, I and anyone in my household needs to quarantine at least until my test results are back and Public Health gives me more instructions". Client expressed verbal agreement with this statement: Yes □ No □

34. Lab/Ordering Provider: _____

Diagnosis Code: _____

***Reminder: Must bring cell phone to testing site. ** Self-Isolation for suspected COVID-19 cases is required until results received.**