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COVID-19 Testing Request

Patient please fill in the form.

Name of Patient:_____. Date of Birth:_____.

I am requesting to be tested for COVID 19 infection. I am responsible for the payment using my own money or insurance payment.

Pertinent information related to the scenario of the testing:

( ) I have had contact with a person who have/had COVID 19 infection recently. Most recent face-to-face contact is: _____days ago.

I have the following symptoms (Y for Yes, N for No): ( ) fever. ( ) cough. ( ) headache. ( ) body ache. ( ) sore throat.

( ) I have no known contact with someone infected with COVID 19 but would like to do the test anyway.

( ) I was previously tested positive for COVID 19, date of test:_____.

( ) I have completed medication treatment for COVID 19, date of completion:_____

I have the following side effects of the medications:_____

_____.

( ) I had symptoms of COVID 19 infection, and the remaining symptoms are:_____

_____.

Patient's Signature _____. Date:_____.