Department of Health & Human Services
Patient COVID-19 Testing Questions

These patient questions must accompany all COVID-19 testing requests. Effective 8-1-20

DATE OF COLLECTION: ___________________________________

PATIENT NAME: ____

PATIENT DOB: ____

ORDERING PROVIDER: __________________________________

OFFICE OR FACILITY: ___________________________________

COMPLETED BY: _______________________________________

Question: CHECK APPROPRIATE ANSWER YES/NO/ UNKNOWN	YES	NO	UNKNOWN
1. First test?			
2. Employed in healthcare?			
3. Symptomatic as defined by CDC?			
if yes, then Date of Symptom Onset mm/dd/yy DATE:			
4. Hospitalized?			
5. ICU?			
6. Resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting):			
7. Pregnant?			

Rev 7 16 20