SALIDA PHARMACY & FOUNTAIN
EST. 2019

Phone: 719-530-4790
Fax: 719-530-4791

SCREENING/IN-TAKE FORM: SARS-CoV-2

Upon suspicion of COVID, we have performed a preliminary screening based on the CDC symptoms with the patient's consent.

Primary Care Provider _____ Phone _____ **Date** _____

Patient Information: Name _____ Date of Birth: _____ Age:_____

Phone Number: _____ Email: _____

Address: _____ City/State/Zip: _____

Please check below if any of these apply to you. If so, you are considered HIGH RISK.

Over 65 _____ Heart Condition _____

Cancer _____ Immunocompromised_____

Chronic Kidney disease _____ Obesity _____

COPD _____ Sickle Cell Disease _____

Smoker _____ Type 2 Diabetes _____

Pharmacy Use Only

Temp: _____

BP1 ____ /____ Pulse _____

Drug Allergies: _____

Current Symptoms

SARS-CoV-2

- ☐ Fever >100.4°F
- ☐ Sore throat
- ☐ Runny nose
- ☐ Stuffy nose
- ☐ Muscle aches
- ☐ Shortness of breath/difficulty breathing
- ☐ New loss of taste or smell
- ☐ Cough
- ☐ Headache
- ☐ Fatigue (tiredness)
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Chills
- ☐ Asymptomatic

How long have you had symptoms? _____ **Actions taken to date:** _____

Assessment

Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with:

Anyone who is known to have laboratory-confirmed COVID-19? Yes or No

OR

Anyone who has any symptoms consistent with COVID-19? Yes or No

Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are you worried that you may be sick with COVID-19? Yes or No

Are you currently waiting on the results of a COVID-19 test? Yes or No

Consent

I hereby authorize the pharmacist from Buena Vista Drug to perform a Covid-19 Rapid Antigen Test. I authorize the pharmacists to maintain a copy of this signed form. I indemnify the organizing body and all persons connected with them from any and all claims that may result from my voluntary participation in the tests. I understand that my results will be submitted to the Colorado Department of Health, as required by law.

By signing below, I signify that I agree to allow those pharmacists affiliated with the pharmacy named above to administer the Covid-19 test for a fee of $75.00.

I understand the test that I am receiving is a rapid diagnostic test using antigens. Antigen tests look for viral proteins, which are highly specific, meaning that if you test positive, you are very likely infected. However, there is a higher chance of false negatives with antigen tests, which means that a negative result cannot definitively rule out an active infection. If you have a negative result on an antigen test but have a recent exposure to Covid, or are displaying many of the symptoms, you may wish to take a PCR test to confirm your result. A PCR test looks for the presence of the virus's genetic material. PCR tests are highly accurate, but can take days to a week to get the results. The antigen test that you are receiving today is most accurate if you are symptomatic and within the first five days of symptoms.

If you are testing to meet a travel requirement, it is your responsibility to determine if you are required to take a PCR test or an antigen test. The test you are receiving today is an antigen test.

- ○ **I understand if my results are positive I should follow-up with my primary care provider.**

Patient's Signature: _____ **Today's Date:** _____

Representative Signature (if applicable) _____ **Date** _____

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COVID 19 Consult $55

Results *(Pharmacy Use Only)*

Test Result Positive _____ Negative _____

Date: _____ Pharmacist Name _____

Pharmacist's Signature: _____

Pharmacist Follow-Up within 48 hours

Date: _____Pharmacist:_____

PHARMACY TO COMPLETE:

Date test ordered: _____

Date specimen collected: _____

Accession # / Specimen ID: _____

Ordering provider name and NPI: Salida Pharmacy & Fountain 1740821289

Ordering provider zip: 81201

Facility name and CLIA number: Salida Pharmacy & Fountain / 06D2181384

Performing facility zip code: 81201

Specimen Source – Nasal swabs 445297001

CPT Code 87426

ICD10: (Circle based on screening)

Z20.828 (use for exposure to confirmed case)

Z03.818 (use for suspected exposure)

U07.1 (add if a positive result is received)

Rapid Detection of SARS-CoV-2

BD Veritor™ System Test Device Lot: _____ Exp: _____
Sensitivity: 84%, Specificity: 100%, 16% chance of false negative

You can be around others if you tested positive:
10 days after symptoms first appeared
and
24 hours with no fever without the use of fever-reducing medications
and
Other symptoms of COVID-19 are improving*
*Loss of taste and smell may persist for weeks or months after recovery and need not delay the end of isolation

Note that these recommendations do not apply to persons with severe COVID-19 or with severely weakened immune systems (immunocompromised).
https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/end-home-isolation.html
https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

To protect patient privacy, any data that state and jurisdictional health departments send to CDC will be deidentified and will not include some patient-level information. The deidentified data shared with CDC will contribute to understanding COVID-19's impact, positivity trends, testing coverage, and will help identify supply chain issues for reagents and other materials.