Patient Information

Patient Name: _____

Patient DOB (mm/dd/yyyy): _____ **Gender:** M / F

Street Address: _____

City: _____ **State**: _____ **ZIP**: _____

Cell Phone #: _____ **Primary Care Dr:** _____

Email: _____

Clinical History

☐ fever ☐ cough ☐ shortness of breath ☐ other _____

Date of onset of symptoms: _____ ☐ N/A

Did you have **known contact** with another COVID-19 **positive** case? ☐ Yes ☐ No

Are you **fully vaccinated** (2 weeks after 2nd dose)? ☐ Yes ☐ No

Are you a healthcare worker or someone who interacts directly with the public? ☐ Yes ☐ No

Have you travelled **14 days prior** to testing? ☐ Yes ☐ No If yes, complete below:

Location: _____ Depart/Return Dates: _____

Consent

I give permission to Caring Wellness Pharmacy to collect my specimen and send it to Infinity Lab and for the lab to report the result to the state as required by law. I understand that my personal information will not be shared in compliance with Health Insurance Portability and Accountability Act (HIPAA).

Name: _____**Signature**: _____**Date**: _____