PURSUANT TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ONLY INDIVIDUALS WHO MEET ONE OR MORE OF THE FOLLOWING CONDITIONS SHOULD BE TESTED FOR COVID-19:

- Anyone with symptoms suggestive of COVID-19: cough, shortness of breath or difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste or smell. Other less common symptoms have been reported, including gastrointestinal symptoms like nausea, vomiting, or diarrhea;
- Close contacts of known positive cases, regardless of symptoms;
- Regardless of symptoms, anyone at higher risk of exposure or at a higher risk for severe disease. Such patient populations are persons who live in or have regular contact with high-risk settings (e.g., long-term care facility, homeless shelter, correctional facility, migrant farmworker camp);
- Persons who are at high risk of severe illness (e.g., people over 65 years of age, people of any age with underlying health conditions);
- Persons who come from historically marginalized populations;
- Healthcare workers or first responders (e.g. EMS, law enforcement, fire department, military);
- Front-line and essential workers (grocery store clerks, gas station attendants, etc.) in settings where social distancing is difficult to maintain.

COVID-19 Test

Montgomery County Department of Health

PERSON UNDER INVESTIGATION Patient Information Sheet

Date:_____

PATIENT INFORMATION

First Name:_____ Last Name:_____ Phone:_____

Date of Birth: ___/____/____ Age:____ Sex: □ Male □ Female Race: _____ □Hispanic □Non-Hispanic

Address: _____ City:_____ State_____ Zip Code_____

Email: _____ County_____ Employer:_____

_____

Primary Physician/Provider:_____

Primary Physician Address:_____

Primary Physician Phone Number:_____

_____

I have : □ NO INSURANCE □MEDICAID ID NUMBER: _____ □OTHER

Insurance Company:_____ Telephone Number:_____

Subscriber ID #:_____ Group #:_____

Name of Insured on Card:_____

CLINICAL INFORMATION

Do you have symptoms: □YES □NO If symptomatic, onset date_____

Please check symptoms below you are experiencing or leave blank if no symptoms/asymptomatic

□ Fever >100.4 F □Chills □Muscle Aches □Runny Nose □Sore throat □Cough □Headaches

□Shortness of breath □Nausea or Vomiting □Abdominal Pain □Diarrhea >3 loose stools in a day

Other symptoms not listed:_____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? Only check the ones you have:

I have pre-existing medical conditions: □YES □NO

□Chronic Lung Disease (asthma/emphysema/COPD □Diabetes Mellitus □Cardiovascular Disease
□Chronic Renal Disease □Chronic Liver Disease □Immunocompromised Condition □Current Smoker
□Neurologic/Neurodevelopmental Condition □Former Smoker □If female, currently pregnant
□Other_____

History/Additional Information required for testing

Do you work in a health care facility or congregate setting? (e.g. long term care, prison, jail)
□YES □NO If yes, Facility Name:_____ Your Occupation:_____
Did you work while ill? □YES □No Last Day of work:____/___/___
Do you live in a congregate setting? □YES □NO If yes, facility name:_____
Are you a close contact of a known positive COVID case? □YES □NO

I attest and voluntarily consent to the following:

□ COVID-19 testing
□ Release of my results to my Primary Care Provider
□ Release of medical information to process my insurance claim.
□ Reviewed the "Notice of Privacy Practices" for Montgomery County Health Dept @ www.montgomerycountync.com
□ Received "Coronavirus Disease 2019 Guidance for Persons Under Investigation"

_____ _____
Signature Date

For Health Department Use Only
Specimens for COVID -19 Testing: Specimen #_____ Date of Specimen_____
Specimen Type: □NP □OP Other:_____ Sent to: □State Lab □Quest □_____
Specimen Collected by: □ Amy Taylor, MLT Nurse:_____ Paramedic:_____

NOTICE TO PATIENT:

(1) BY SUBMITTING TO THIS TESTING YOU RECOGNIZE YOURSELF AS A PERSON UNDER INVESTIGATION FOR COVID-19. THIS TESTING IS BEING CONDUCTED AS PART OF A PUBLIC SAFETY OUTREACH, AIMED AT HELPING CURTAIL THE SPREAD OF A HIGHLY INFECTIOUS AND POTENTIALLY DEADLY VIRUS. YOU SHOULD TAKE ALL PRECAUTIONS TO RESTRICT CONTACT WITH OTHER PEOPLE. YOU SHOULD PRACTICE THE 3 W'S AT ALL TIMES: WEAR A MASK, WASH YOUR HANDS REPEATEDLY, AND WAIT AT LEAST SIX FEET APART WHILE IN CONFINED SPACES.

(2) THE MONTGOMERY COUNTY HEALTH DEPARTMENT IS NOT RESPONSIBLE FOR PATIENT CARE RELATED TO THIS TEST. PATIENTS WHO DEVELOP SYMPTOMS OR WHOSE SYMPTOMS WORSEN SHOULD CONTACT THEIR PRIMARY CARE PHYSICIAN, THE EMERGENCY ROOM, OR CALL 911.