SANFORD LABORATORIES

COVID-19 TESTING - PATIENT INTAKE FORM

Effective August 1, 2020 section 18115 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law 116-136) requires all clinical laboratories to report demographic data on each individual tested for COVID-19. Failure to report COVID-19 test results along with demographic data may result in revocation of a laboratory's clinical lab permit. We appreciate your compliance with this new regulation.

DEMOGRAPHIC INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE NAME:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

COUNTY: _____ **PHONE NUMBER:** _____

RACE:

- ☐ WHITE
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ ASIAN
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ OTHER
- ☐ DECLINED
- ☐ UNAVAILABLE/UNKNOWN

ETHNICITY:

- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ DECLINED
- ☐ UNAVAILABLE/UNKNOWN

Healthcare providers can answer the following questions on behalf of the individual tested for COVID-19:

TEST QUESTION	ANSWER OPTIONS	NOTE/DETAILS
First Test?	___ Yes ___ No ___ Unknown	Is the patient being tested for COVID-19 for the first time?
Employed in Healthcare?	___ Yes ___ No ___ Unknown	Clinicians, Clinic/Hospital Staff, First Responders, Caregivers, etc.
Symptomatic as defined by the CDC?	___ Yes ___ No ___ Unknown	CDC Symptoms: Fever/chills, cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste or smell, congestion/runny nose, sore throat, nausea/vomiting, diarrhea.
Date of Onset:	Date:	
Hospitalized?	___ Yes ___ No ___ Unknown	Is this patient currently admitted to a hospital?
ICU?	___ Yes ___ No ___ Unknown	Is this patient currently admitted to an ICU?
Resident in a congregate care setting?	___ Yes ___ No ___ Unknown	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.
Pregnant?	___ Yes ___ No ___ Unknown	
Pre-Procedure/Pre-Operation?	___ Yes ___ No ___ Unknown	Is this patient scheduled for a procedure/operation in the near future?
Date of procedure/operation:	Date:	