FOOTHILLS HEALTH DISTRICT
COVID-19 TESTING, REGISTRATION, CONSENT, AND ENCOUNTER FORM

***Please provide the following information:**

Today's Date:_____/_____/_____ Date of Birth:_____/_____/_____

First Name:_____ Last Name:_____

Parent/Guardian Name (If Applicable):_____

Address:_____ City:_____ State: _____

Zip Code:_____ County:_____ Phone Number:_____

Social Security Number:_____-_____-_____ Race: _____

Male: _____ Female: _____ Ethnicity:_____

Employer:_____ Do you work in a healthcare facility?_____

***Clinical Information:**

Who is your family doctor? _____

Do you have symptoms of COVID-19_____ If yes, when did they start?_____

Please check below any symptoms that you are having today:

_____ Fever over 100.4 _____Chills _____Muscle Aches _____Runny Nose _____Cough

_____Sore Throat _____Shortness of Breath _____Nausea or Vomiting

_____ Abdominal Pain _____Diarrhea (3 or more loose stools in a day)

***Health History:**

Is this your first COVID-19 test:_____ If not, when were you tested before?_____

Have you been hospitalized for COVID-19? _____ Were you in ICU? _____

Are you a resident of a congregate care setting (nursing home, group home, homeless shelter, treatment facilities, foster home, etc.)? _____

If so, name of home: _____

Are you currently pregnant? _____ Please check any conditions that apply to you:

_____Asthma/Emphysema/COPD _____Diabetes _____Heart Disease _____Current/Former Smoker

_____Kidney Disease _____Liver Disease _____Immunocompromised _____Neurological Problem

Other:_____

Please complete other side of form →

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COVID-19 Testing : Informed Consent

Please carefully read and sign the following Informed Consent:

- **I authorize the Foothills Health District to conduct collection and testing for COVID-19 through a nasopharyngeal. I understand that this test is performed at the NC State Laboratory of Public Health and results can take up to 7 days to return.**

- **I understand the Foothills Health District is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.**

- **I understand that these test results are confidential and I have been given access to information regarding HIPAA guidelines for the Foothills Health District via their website:** www.foothillshd.org/privacy_en

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

_____ _____

Patient Printed Name Patient/Legal Guardian Signature

_____ _____

Witness Date

FOR HEALTHDEPARTMENT USE ONLY

Dx Code: (circle one)

U07.1 (already had + test, retest, has signs & symptoms)

Z11.59 (no signs or symptoms and no known exposure)

Z03.818 (possible exposure)

Z20.828 (exposed)

CPT Code:

U0001 Provider Number_____

plus select one of these:

99000 Provider Number _____(FHD test)

99001 Provider Number _____ (pickup)