COVID-19 RAPID TESTING – KEY WEST, FLORIDA

Date:_____ Testing Site:_____

PRINT Patient name (Last, First)_____

Patient Phone Number(___)_____

Email_____

Patient Address_____

City_____ State_____ Zip Code_____

Race	Ethnicity
( ) African-America/Black	( ) Hispanic/Latino
( ) Asian/Pacific Islander	( ) Not Hispanic/Latino
( ) Native American	Sex
( ) White	( ) Female
( ) Other	( ) Male
	( ) Other

DOB (_____/_____/_____)

M D Yr

Occupation_____ Employer_____

Have you tested POSTIVE for Covid-19 ( ) YES ( ) NO ( ) NEVER TESTED

Do you have fever, shortness of breath, coughing, Flu like symptoms, body aches? ( ) Yes ( ) No

Have you had contact with a POSITIVE Covid-19 case ( ) YES ( ) NO ( ) UNKNOWN

Do you have any preexisting medical conditions, if yes list:_____

Did you travel outside of Florida or Internationally in the last 6 months ( ) YES ( ) NO

Covid-19 Antigen Result:_____

PCR TEST Required Y:_____ N:_____ Referral Given?_____

Test Administrator:_____