BayCare COVID-19 Screening Form - TPA

Must answer all questions below and then proceed with Testing if YES: ☐ **Re-test**

Within the **last 5 days** have you experienced:
Cough, shortness of breath, fever, chills, shaking with chills, headache, muscle pain, sore throat, sudden loss of taste or smell, congestion, runny nose, nausea, vomiting, diarrhea? (Dx: Z20.828) ☐ YES ☐ NO

Date of onset of symptoms: _____ N/A

Resident in congregate living setting, including prisons and shelters?	☐ YES	☐ NO
Is this your first COVID-19 test?	☐ YES	☐ NO
Healthcare worker, worker in congregate living setting, or first responder?	☐ YES	☐ NO
Is patient in ICU?	☐ YES	☐ NO
Is patient hospitalized?	☐ YES	☐ NO
Are you pregnant?	☐ YES	☐ NO
Is this testing travel related?	☐ YES	☐ NO

If YES, e-mail address:_____

PLEASE PRINT LEGIBLY AND USE BLOCK LETTERS

Patient Name_____ **D.O.B.**_____/_____/_____ **Gender:** _____
Last **First** **MM / DD / YYYY**

SSN: __ __ __ - __ __ - __ __ __ __ **Ethnicity Group:** ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

Race: [ ]American Indian/Alaska Native [ ]Asian [ ]Black/African American [ ]Native Hawaiian/Pacific Islander [ ]Other Race [ ]White

Mobile Phone: _____

Zip code:_____ **Verbal consent to receive COVID-19 results via text message?** ☐ **YES** ☐ **NO**

☐ **Pinellas** ☐ **Hillsborough** ☐ **Pasco** ☐ **Polk** ☐ **Manatee** ☐ **Other:**_____

Order – Lab Client: TIA COVID JH (8021) [ ] COVID BC (PCR)

[ ] Rapid Antigen Testing Lot#_____ Controls +/- _____ Kit Expiration Date_____

Clinician's initials_____ Date_____ Time_____

Display	Interpretation
CoV2: +	Positive Test for SARS-CoV-2 (antigen present)
CoV2: -	Presumptive Negative Test for SARS-CoV-2 (no antigen detected)
CONTROL INVALID	Test Invalid.* Repeat the test.

Depart Instructions: Written instructions provided to patient regarding follow up and warning signs to seek more urgent care.

Printed Name: ___Dr. Jacquelyn Cawley____Provider NPI:_1346299146____ Date: _____