|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name:** | | **Last Name:** | | | | | **Record Number:** (To be entered by CLCHD Staff Only) |
| **Date of Birth**: (00/00/0000) | | **Age**: | | | **Date of Testing:** | | **Gender**:  Male Female |
| **Street Address**: (No PO Box) | | **City**: | | | | | **State:** |
| **Zip Code**: | **County:** | | **Phone Number:**  ( ) - | | | **Do you live in a communal living setting?**  Yes No | |
| **Facility Completing Testing;**  Cheyenne Laramie County Health Depart | | **Submitter Phone Numbers:**  (307) 633-4000 | | | | | **Submitter Fax Number**:  (307) 633-4066 |
| **Date of Symptom Onset:**  Date:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  No Symptoms | | **Symptoms:** (Check all that apply)  Fever > 100.4 Subjective Fever Cough  Shortness of Breath Muscle Aches Sore Throat  Runny Nose Nausea &/or Vomiting Headache  Abdominal Pain Loss of Taste &/or Smell Diarrhea  Other: | | | | | |
| **Have you tested positive for the Flu?**  Yes No  **Have you tested positive for RSV?**  Yes No | |
| **Have you been tested for COVID 19 Before?**  Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_    Testing Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Results: Positive Negative  Was this a Rapid Test? Yes No | | | | **Medical Health History:** (Check all that Apply)  COPD Asthma Emphysema  Obesity Diabetes Chronic Renal Disease  Immunocompromised Chronic Liver Disease  Neurological Disease Intellectual Disability  Female Only: Are you Pregnant? Yes No  Current Smoker? Yes No  Past Smoker? Yes No | | | |
| **Travel History:**  In the past 14 days, did you travel? Yes No  If yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | **Exposure History:**  Are you a healthcare worker providing direct patient care? Yes No  If yes: Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Have you had contact with a confirmed COVID-19 person? Yes No  If yes, Name of Confirmed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**For Cheyenne-Laramie County Health Department Use Only**

Staff Member Name Entering Data into Redcap: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of C-LCHD Staff Member verifying Patient Identifiers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_