CASPER-NATRONA
COUNTY HEALTH DEPARTMENT

CASPER vs. COVID

DATE:

COVID SCREENING & TESTING DOCUMENTATION FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____ Age: _____

Physical Address: _____

City/State/Zip: _____ County _____

Phone: _____ Gender Identity: ☐ Male ☐ Female ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non–Hispanic

Race:
- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other

PATIENT QUESTIONNAIRE

1. Description of symptoms: _____ Onset Date: _____

2. Please mark any of the following conditions that apply to you:
   - ☐ BMI of 25 or greater
   - ☐ Chronic kidney disease
   - ☐ Diabetes
   - ☐ Immunosuppressive disease
   - ☐ Receiving immunosuppressive treatment
   - ☐ 65 years of age or older
   - ☐ Cardiovascular disease
   - ☐ Hypertension
   - ☐ COPD/other chronic respiratory disease
   - ☐ Pregnancy
   - ☐ Sickle cell disease
   - ☐ Neurodevelopment disorder or other conditions that confer medical complexity
   - ☐ Medical related technology dependence (e.g. gastrostomy)
   - ☐ Other high–risk medical condition determined by provider (please describe):
     _____
     _____
     _____
   - ☐ None of the above

3. Have you had close contact with a laboratory confirmed case of COVID–19 in the past 14 days?
   ☐ Yes *(Please provide additional details:*_____*)* ☐ No

4. Have you received a COVID–19 vaccine? ☐ Yes, Pfizer ☐ Yes, Moderna ☐ Yes, Janssen (J&J) ☐ No
   Date of 2nd vaccine: _____ Have you receive a booster dose? ☐ Yes ☐ No

5. Do you live or work in a congregate setting? ☐ Yes ☐ No
   If yes, please explain: _____

6. In the past 14 days, have you traveled? ☐ Yes ☐ No
   If yes, list destinations and dates: _____

7. Are you a healthcare worker? ☐ Yes ☐ No
   If yes, did you provide direct patient care while symptomatic or during the 48 hours prior to symptom onset? ☐ Yes ☐ No
   If yes, identify dates while working: _____

8. Do you have continued close contact with persons over 65 or those with underlying conditions (diabetes, heart disease, lung disease, immunocomprimized?) ☐ Yes ☐ No

Updated January 10, 2022

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CONSENT FOR TESTING, NOTIFICATION, AND FOLLOW UP:

In consideration for services to be rendered to me by Casper Natrona County Health Department and its staff, I hereby apply for and consent to such diagnostic tests/services.

I understand that every attempt will be made to maintain the strictest confidentiality regarding my health care, but in specific circumstances, it may be necessary to temporarily suspend that confidentiality. Limited demographic information and disease reporting information on those individuals receiving services will be provided to the Wyoming Department of Health.

I hereby request that an examiner authorized by the Casper–Natrona County Health Department proceed with the necessary means to collect specimens as needed for testing and diagnosis.

X _____ _____

If Verbal Constent Obtained, signature person of accepting is needed) *Date*

AUTHORIZATION TO COMMUNICATE VIA EMAIL:

When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

I understand the risks of sending/receiving email containing protected health information. I have had the chance to ask questions that were answered to my satisfaction. ***Please only complete this portion if you do not have text messaging capabilities. Please write legibly.***

Based on the information provided to me, it is my decision to:

☐ Allow Unencrypted Email: Email Address: _____

☐ DO NOT Allow Unencrypted Email

_____ Date _____

If Verbal Constent Obtained, signature person of accepting is needed)

TO BE COMPLETED BY CNCHD STAFF ONLY

DOCUMENTATION OF TESTING PROCEDURE

Type of Test: _____

Result (Circle One): **POSITIVE** **NEGATIVE**

_____ _____

Nurse Signature Date and Time