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| --- | --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_