ALABAMA REGIONAL MEDICAL SERVICES

COVID-19 TESTING TRIAGE FORM

Date _____

☐ New Patient ☐ Established Patient ☐ Established Patient Update ☐ BCJ Jail

Patient Name _____DOB _____Age_____ ☐ Male ☐ Female

Address_____ City_____ ST _____ ZIP _____

Insurance Carrier_____ Policy_____ Group Number_____

☐ Self-Pay ☐ Slide

Race: ☐ Black /African American ☐ White ☐ Hispanic ☐ Other _____

Email Address _____ Appointment Time: _____

Cell Phone Number _____ Home Phone Number_____

Coronavirus Symptoms

1. Coronavirus temperature greater than 100.4 Yes ☐ No ☐
2. Cough: New or worsening cough Yes ☐ No ☐
3. Shortness of Breath: New or worsening Yes ☐ No ☐
4. Muscle pain Yes ☐ No ☐
5. Headache sore throat Yes ☐ No ☐
6. New loss of taste or smell Yes ☐ No ☐
7. Fevers/Chills Yes ☐ No ☐

Exposure

1. Have you been in close contact with anyone suspected or confirmed Coronavirus? Yes ☐ No ☐
2. Do you work in a health care facility? Yes ☐ No ☐

High risk PMH

1. Diabetes Mellitus Yes ☐ No ☐
2. Hypertension or Heart Disease Yes ☐ No ☐
3. Asthma/COPD Yes ☐ No ☐
5. Age 65 or greater Yes ☐ No ☐
6. Immunosuppressive illness Yes ☐ No ☐
7. Smoker/Former Smoker Yes ☐ No ☐

MA Signature _____Provider Signature _____