2019 Novel Coronavirus Drive Through Clinic Form

Drive Through Clinic Site | **Date**

Healthcare Provider Contact Information

Provider Name | **Phone Number**

Provider Email Address:

Patient Contact Information

Patient First Name _____

Patient Last Na me _____

Patient Date of Birth ____/____/____

Street Address: _____

City _____

County _____

State _____ **Zi** _____

Phone Number:(_____

Alternate Phone Number: ( ) _____

Patient Sex
o MALE
o FEMALE
o Unknown

Patient Ethnicity
o Hispanic or Latino
□ Not Hispanic or Latino
o Unknown

Patient Race
o American Indian or Alaskan Native
o Asian
□ Black or African American
□ Native Hawaiian or Pacific Islander
o White
□ Other
□ Unknown

Pre-existing Medical Conditions {Check all that apply)
o Chronic Lung Disease
o Diabetes Mellitus
o Cardiovascular Disease
□ Chronic Renal Disease
□ Chronic Liver Disease
o !mmunocompromised
o Neurologic/Neurodevelopmental/ intellectual disability
o Currently Pregnancy

Symptoms Present? o Yes ***o No*** o Unknown
If yes, check all that apply. o Fever >100.4F o Chills
o Muscle Aches □ Runny nose □ Sore throat □ Cough
□ Shortness of breath o Headache □ Abdominal pain
o Diarrhea **Symptom Onset Date_/__/**

Current Smoker o Yes ***D No***
Former Smoker □ Yes o No
Healthcare Worker in US o Yes **o No**

Travel within 14 days of symptom onset? □ Yes o No
If yes, where?

Contact with laboratory Confirmed COVID 19 patient? o Yes ***D No***
Confirmed Case's Name

Specimen submitted to: o ADPH Lab □ Clinical Lab □ Commercial Lab Name
Specimens for COVID 19 testing: o Nasopharyngeal swab □ Sputum □ Other
** Please scan form and email to:

Riverview Regional Medical Center

Riverview Medical Clinic of Rainbow City
Affiliated with Riverview Regional Medical Center