

COVID-19 Specimen Intake Form

PATIENT DETAILS

Full Name: _____ Age: _____ Date of Birth: ____/____/____
Address: _____
Primary Phone Number: _____ - _____ - _____ Gender: Male Female
E-mail (optional): _____

INSURANCE INFORMATION

Primary Insurance Name: _____
Subscriber ID: _____ Group Reference: _____
Secondary Insurance (if covered): _____
Subscriber ID: _____ Group Reference: _____
Primary Physician (optional): _____ Ph. Number : _____ - _____ - _____

CLINICAL DETAILS

Is the patient currently experiencing any of the following symptoms?

Fever (>100.4°F/37°C) Cough Productive cough Shortness of breath No symptoms

UNDERLYING MEDICAL CONDITIONS

Asthma/chronic lung disease? Yes No
Diabetes/renal disease? Yes No
Heart or circulatory disease? Yes No
Cancer in the last 12 months? Yes No
Other (Specify): _____

Has the patient traveled from a location with endemic spread of COVID-19 within the last 14 days? Yes No

If yes, location: _____

Last date in country with endemic spread: _____

Has the patient had contact with a confirmed or suspect COVID-19 case within the last 14 days? Yes No

Has the patient had contact with anyone with an unexplained respiratory illness within the last 14 days? Yes No

PATIENT VITAL SIGNS

Temperature: _____ Pulse: _____ Oxygen level: _____

Submitting Physician's name, facility name and mailing address:

Dr. Hammad Rizvi, DO

90 Main Street
Hackensack, NJ 07601
Ph: 201-880-8112
NPI: 1659516227