JUNEAU URGENT & FAMILY CARE
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COVID-19 Antibody/Virus Testing Questionnaire

Name: _____ **DOB:** _____

Read and check if you **CURRENTLY HAVE** any of the following conditions or symptoms:

- ☐ Fever
- ☐ Shortness of breath or difficulty breathing
- ☐ Diarrhea
- ☐ Generalized Muscle pain
- ☐ Cough
- ☐ Sore throat
- ☐ Vomiting
- ☐ Headaches
- ☐ Loss of taste or smell
- ☐ Chest Pressure
- ☐ Dizziness or Lightheadedness
- ☐ Stuffy nose
- ☐ Nausea, vomiting
- ☐ Tiredness

IF ANY ARE MARKED A PROVIDER VISIT IS REQUIRED

VIRAL COVID PCR TESTING

Check any of the following pertain to you:

- ☐ I work with the public or have been in public spaces and believe that I might have been exposed
- ☐ Have visited or been with someone who works in a long-term care facility
- ☐ In the last 2 weeks have you visited an emergency room, volunteered as a firefighter/ambulance, visited a medical office or taken care of someone who is ill?
- ☐ Have you been in close contact with someone who has tested positive for COVID-19? Close contact is defined as being within 6 feet of a known or suspected COVID-19 individual for 10 minutes or more.
- ☐ Have traveled outside of Juneau OR had close contact with someone who traveled within the past 14 days/ intend to travel

Antibody testing only

Since January List Symptoms that makes you suspect that you may have been exposed to COVID? **List Past Symptoms and approximate Date**:

_____

To be filled out by Medical Staff: **Temperature:** _____ **MA initials:** _____

Declination of Provider Visit

☐ I do not wish to have a medical evaluation, fully understanding there will be NO ADDITIONAL COST to be seen.

I understand that signs and symptoms of Covid may mimic other diseases and illnesses that could also appear in a short time frame just as Covid. Failure to be seen by a Provider to assess the need for further treatment could result in permanent disability and even death. I understand this and decline to be seen by a provider and request to have the testing for Covid Virus detection as a sole procedure performed**.** **In case of an emergency I will call 911.**

I have truthfully responded to all above questions and understand that lying could impact the health and outcome of my medical evaluation and treatment. I have been given the opportunity to be evaluated by a licensed medical provider. However, I decline to be evaluated at this time.

In consideration of the above no-copay courtesy, I agree that any actions taken against the practice & its representatives will include a review by a board-certified practicing full-time medical expert. You are free to decline to sign this form and see a different medical provider/clinic.

Patient Signature: _____ **Date:**_____