COVID-19 RAPID TEST

RISK ASSESSMENT

Dear Patient,

Before scheduling your COVID-19 Rapid Test , please respond to the following questions.

(Please circle)

1. Do you currently have or have you had a fever (100.4°F or higher) in the past 2 weeks ? YES NO
2. Do you currently have or have you had a cough in the past 2 weeks ? YES NO
3. Do you currently have or have you had shortness of breath or difficulty breathing in the past 2 weeks ? YES NO

4. Do any of the people you have close contact with have similar symptoms ? YES NO
5. Have you travelled outside the U.S. in the past 2 weeks ? YES NO
6. Are you a healthcare worker who has had a recent exposure to an individual presenting symptoms of respiratory illness ? YES NO

If your answer is “YES” to any of them, you are not a candidate for our test. We apologize and recommend visiting one of the local hospitals or designated locations providing medical service to people presenting COVID-19 related symptoms.

Patient Name:_____ Date: _____

Patient Signature:_____

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