

FOXHALL

INTERNISTS, PC

We are required by the D.C. Health Department to provide them with the following information with each test for COVID-19 collected in our lab. Kindly complete this form in advance of your testing appointment and bring it with you.

Name _____ Contact phone number (_____) _____

Address _____ Date _____

Signature _____

1. Is this your first test for COVID-19?
 Yes No

2. Are you employed in healthcare?
 Yes No

3. Have you had symptoms of a COVID-19 infection?
 Yes No

4. If yes, what day did your symptoms begin? _____ (MM/DD/YYYY)

5. Have you been hospitalized for a COVID-19 infection?
 Yes No

6. If yes, did you require care in the ICU?
 Yes No

7. Have you lived in a congregate care home this year? (examples include group homes, residential care facilities, or maternity homes)
 Yes No

8. Are you pregnant?
 Yes No

9. Race
 Asian Black or African American American Indian or Alaska native
 Native Hawaiian or other Pacific Islander White
 Other/not given

10. Ethnicity?
 Hispanic Non-Hispanic Not Given