

Date: _____



Serenity Mental Health & Serenity Health



CORONAVIRUS SCREENING FORM

Patient Name: _____ Phone#: _____

DOB: _____ Insurance Carrier: _____ Policy#: _____

TEMPERATURE		HEIGHT		WEIGHT		Blood Pressure	
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1. Have you traveled outside of the USA in the last 14 days?
2. Have you traveled within the USA in the last 14 days?
3. Have you been on a cruise ship in the last 14 days?
4. Have you been in close contact with anyone who has traveled domestically or internationally in the last 14 days?
5. Have you attended any events or gatherings with more than 100 people in the last 14 days?
6. Have you been in close contact with a person known to have the Novel Coronavirus?
7. Have you been asked to self-quarantine?
8. Have you had any fever or chills in the last 14 days?
9. Do you currently have any lower respiratory symptoms such as a cough, wheezing, or shortness of breath?
10. Do you have a new onset of other cold symptoms such as a runny nose or sore throat?
11. Do you work in a Hospital, ER, Urgent Care, or high-risk job? If so, where? _____
12. Are you over the age of 65?
13. Do you have any Chronic conditions?
14. Do you have a preferred pharmacy? Name, Address, Phone#? _____

	YES	NO

- If you are APPROVED for the test, go to the instructed location at the instructed time.*
- You will stay in your car and be swabbed. 1 Test given per car.*
- It may take up to 3-5 Days for Test Results, but please be assured EVERYONE will be contacted with their results as soon as they come in.*
- Please Self Quarantine Until Results are Given*
- Follow any Instructions given by Provider*
- If symptoms worsen, go to nearest Hospital or call 911 in the event of an emergency.*
- Email completed form to COVID19@SERENITYMENTALHEALTH.ORG along with your ID and Front & Back image of your insurance card or indicate "NO INSURANCE". Put your name in the subject line and your phone number in the body of the email.*

Any missing information will disqualify you for services and testing.

Signature: _____

Date: _____