PTS or REFERRING OFFICE: PLEASE CALL CLINIC TO PRE-SCHEDULE TESTING APPOINTMENT

MH Urgent Care: Middletown - Phone: 860-788-3632 / Fax: 860-788-2085

Madison - Phone: 203-779-5207 / Fax: 203-779-5792

When patient arrives at clinic, please have them call again to announce their arrival prior to entering.

Middlesex Health

COVID-19 TEST ORDER FORM

Patient Name: _____ DOB: _____ MR#: _____ (if known)

Order: COVID-19 PCR Anterior Nares Swab Test ☐

Exposure to COVID - 19: None ☐ Possible ☐ Definite ☐ Date of Exposure/Sx onset:_____

During this illness, did the patient experience any of the following symptoms	Symptom Present?
Fever > 100.4F (38C)	Yes ☐ No ☐ Unk ☐
Subjective Fever (felt feverish)	Yes ☐ No ☐ Unk ☐
Chills	Yes ☐ No ☐ Unk ☐
Muscle Aches (myalgia)	Yes ☐ No ☐ Unk ☐
Runny Nose (rhinorrhea)	Yes ☐ No ☐ Unk ☐
Sore Throat	Yes ☐ No ☐ Unk ☐
Cough (New onset of worsening of chronic cough)	Yes ☐ No ☐ Unk ☐
Shortness of breath (dyspnea)	Yes ☐ No ☐ Unk ☐
Nausea or vomiting	Yes ☐ No ☐ Unk ☐
Headache	Yes ☐ No ☐ Unk ☐
Abdominal pain	Yes ☐ No ☐ Unk ☐
Diarrhea (≥3 loose/looser than normal stools/24hr period)	Yes ☐ No ☐ Unk ☐
Other, specify:	Yes ☐ No ☐ Unk ☐

Pre-existing Medical Conditions?	
Chronic Lung Disease (asthma/emphysema/COPD)	Yes ☐ No ☐ Unk ☐
Diabetes Mellitus	Yes ☐ No ☐ Unk ☐
Cardiovascular disease	Yes ☐ No ☐ Unk ☐
Chronic Renal disease	Yes ☐ No ☐ Unk ☐
Chronic Liver disease	Yes ☐ No ☐ Unk ☐
Immunocompromised Condition	Yes ☐ No ☐ Unk ☐
Neurologic/neurodevelopmental	Yes ☐ No ☐ Unk ☐ (If yes, specify)
Other chronic diseases	Yes ☐ No ☐ Unk ☐ (If yes, specify)
If female, currently pregnant	Yes ☐ No ☐ Unk ☐
Current smoker	Yes ☐ No ☐ Unk ☐
Former smoker	Yes ☐ No ☐ Unk ☐

To be filled out by the Ordering Provider:

Signature _____ NPI# _____

Print Name:_____ Fax #:_____