

**Help us find you:**

**Best number to call you while in car:** \_\_\_\_\_ **Color and make of car:** \_\_\_\_\_

**COVID-19 Screening Form (Fill out completely)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you been seen at a HAPPI office in the last 3 years? \_\_\_Yes \_\_\_No SSN or Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance: \_\_\_\_\_ *(please have card and ID for the parking lot staff to collect)*

Birth Date: \_\_\_\_\_ School or Employer Name: \_\_\_\_\_

School/Employer fax/ email to send results (\*signature at bottom of pages is consent to send results) \_\_\_\_\_

Best phone number to contact/ text: \_\_\_\_\_

Recent: Height: \_\_\_ Weight: \_\_\_ Temp: \_\_\_\_\_

**Ethnicity:** Hispanic/Latino Non Hispanic/Latino **Race:** White Black Other \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Have you had contact with a person with a confirmed case of COVID-19?

\_\_\_ Yes \_\_\_ No Have you had contact with a person with a suspected case of COVID-19?

\_\_\_ Yes \_\_\_ No Have you had a fever within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you had a forceful dry cough or productive cough within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you had difficulty breathing or shortness of breath within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you had chills or repeated shaking with chill within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you had new unexplained muscle pain within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you had new or atypical headache for you within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you had nausea, vomiting or diarrhea within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you had a sore throat within the last 14 days?

\_\_\_ Yes \_\_\_ No Have you been tested for COVID-19 in the last 2 weeks?

\_\_\_ Yes \_\_\_ No Have you had a recent sudden loss of taste or smell?

\_\_\_ Yes \_\_\_ No Are you pregnant?

\_\_\_ Yes \_\_\_ No Are you a health care worker?

Rapid:  
Flu:  
Sendout:

**Circle or Mark Applicable**

**Language Preference:** English Spanish Other: \_\_\_\_\_

**Who lives at in your home (relation)?** Spouse Sibling Parent(s) Children Partner Roommate Other

**Medications** \_\_\_\_\_

Please list any Medical Problems: \_\_\_\_\_

Are you allergic to any medications: \_\_\_No \_\_\_Yes: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Signature is consent for release of COVID test results to school and/or employer as above, to receive notifications from HAPPI including text of results and general consent for treatment. Please ask for a full consent form for any clarification, including your HIPAA rights

**1 PATIENT INFORMATION**

Last Name / First Name / M.I. \_\_\_\_\_  
 Address / APT# \_\_\_\_\_  
 City / State / Zip / County \_\_\_\_\_  
 Phone # \_\_\_\_\_ Email \_\_\_\_\_  
 DOB / / \_\_\_\_\_ SSN \_\_\_\_\_  
 Insurance \_\_\_\_\_ Subscriber ID \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Bill to:  Insurance  Facility  Uninsured  
 Male  Female  
 Race:  Asian  Black  Caucasian  Hispanic  Native American  Other  N/A  
 Ethnicity:  Hispanic  Non-Hispanic  N/A

**2 PROVIDER INFORMATION**

Client Name / Account # HAPP Health  
 Address / APT# 807 Franklin St. SE  
 City / State / Zip Huntsville, AL 35801  
 Phone # 256-519-3650 Fax # 256-585-6713  
 Ordering Provider A. Andrews  
 Specimen Collected By \_\_\_\_\_  
 State Collected \_\_\_\_\_  
 Collection Date \_\_\_\_\_  
 Collection Time  AM  PM

**3 MEDICAL NECESSITY**

As part of my antibiotic stewardship policy, I find it medically necessary to rapidly determine and differentiate a viral and/or bacterial infection in order to treat with or without appropriate antibiotics. Having the most accurate and timely data available to me directly guides my treatment and patient management. Empiric treatment and management leads to inappropriate and unnecessary antibiotic use (50% according to the CDC) and delayed diagnosis which can lead to severe consequences.

Provider Signature: \_\_\_\_\_  
 Verbal Order  Standing Order

**4 CONSENT FOR TESTING**

The information I have provided on this form is accurate. I authorize Assurance Scientific Laboratories to release the results of this test to my treating physician or facility. I hereby authorize my insurance or other payment to Assurance Scientific Laboratories for services I receive. I am aware that Assurance Scientific Laboratories may be an out of network provider with my insurer. I am aware that I am responsible for all co-pays and deductibles not covered by insurance or other payers.

**5 PANEL LIST: Please check appropriate panels that address your patients needs. Tests can be ordered individually.**

<input type="checkbox"/> COVID-19 Only <input checked="" type="checkbox"/> COVID Respiratory Lite COVID-19 (Coronavirus) Influenza A & B Haemophilus influenzae Moraxella catarrhalis Mycoplasma pneumoniae Strep. pyogenes (Group A) <input type="checkbox"/> COVID Respiratory (includes all the pathogens in the panel above) Adenovirus Rotavirus Bordetella pertussis Chlamydia pneumoniae Coronavirus (229E, HKU1, NL63, OC43) EBV (mononucleosis) Enterovirus IMPV A & B Parainfluenza virus (type 1-4) Rhinovirus (types A & B) RSV (types A & B) Staphylococcus aureus Streptococcus pneumoniae <input type="checkbox"/> COVID Respiratory Plus (includes all the pathogens in the panel above) Acinetobacter baumannii Enterobacter cloacae Klebsiella aerogenes Klebsiella pneumoniae Legionella pneumophila Proteus mirabilis Pseudomonas aeruginosa Staphylococcus epidermidis <input type="checkbox"/> ABX Resistance Marker Methicillin/Oxacillin (mecA) <b>ICD 10 CODES</b> R09.81 Congestion J02.9 Pharyngitis J05 Cough <input type="checkbox"/> R50.9 Fever Z20.89 Exposure SPECIMEN SOURCE: Nasal Swab Nasopharyngeal Swab Oropharyngeal Swab Sputum Other: <u>mid-turbinate</u>	<input type="checkbox"/> UTI w/ ABX Resistance Acinetobacter baumannii Bacteroides fragilis Citrobacter braakii/freundii Citrobacter koseri Enterobacter cloacae Enterococcus spp. Escherichia coli Klebsiella aerogenes K. oxytoca/michiganensis Klebsiella pneumoniae Morganella morganii Proteus mirabilis Pseudomonas aeruginosa Serratia marcescens Staphylococcus aureus Staphylococcus epidermidis Staphylococcus saprophyticus Strep. pyogenes (Group A) <input type="checkbox"/> ABX Resistance Markers β-lactamase (blaKPC) β-lactamase (CTX-M-Group 1) metallo-β-lactamase (blaNDM) Fluoroquinolones Methicillin/Oxacillin (mecA) Sulfonamides Trimethoprim Vancomycin (vanA, vanB) <input type="checkbox"/> UTI Plus (includes all the pathogens in the panel above) Candida albicans Candida dubliniensis Candida glabrata Candida krusei Candida parapsilosis Candida tropicalis Mycoplasma genitalium Mycoplasma hominis Prevotella bivia Strep. agalactiae (Group B) Ureaplasma urealyticum <b>ICD 10 CODES</b> R35.0 Frequency of Micturition Z22.39 Carrier of other specified bacterial disease N39.0 Urinary Tract Infection, site not specified R30.0 Dysuria SPECIMEN SOURCE: <input type="checkbox"/> Clean catch urine <input type="checkbox"/> Urethral swab <input type="checkbox"/> Other:	<input type="checkbox"/> Wound/Infection w/ ABX Resistance Acinetobacter baumannii Bacteroides fragilis Citrobacter braakii/freundii Citrobacter koseri Enterobacter cloacae Enterococcus spp. Escherichia coli Klebsiella aerogenes K. oxytoca/michiganensis Klebsiella pneumoniae Morganella morganii Proteus mirabilis Pseudomonas aeruginosa Serratia marcescens Staphylococcus aureus Staphylococcus epidermidis Staphylococcus saprophyticus Strep. pyogenes (Group A) <input type="checkbox"/> ABX Resistance Markers β-lactamase (blaKPC) β-lactamase (CTX-M-Group 1) metallo-β-lactamase (blaNDM) Fluoroquinolones Methicillin/Oxacillin (mecA) Sulfonamides Trimethoprim Vancomycin (vanA, vanB) <b>ICD 10 CODES</b> L08.9 Local infection of the skin and subcutaneous tissue, unspecified Z22.39 Carrier of other specified bacterial diseases Z22.322 Carrier or suspected carrier of MRSA SPECIMEN SOURCE: <input type="checkbox"/> Swab <input type="checkbox"/> Aspiration <input type="checkbox"/> Other:	<input type="checkbox"/> Vaginitis Atopobium vaginae Bacteroides fragilis BVAB-2 Candida albicans Candida dubliniensis Candida glabrata Candida krusei Candida lusitanae Candida parapsilosis Candida tropicalis Chlamydia trachomatis Enterococcus spp. Escherichia coli Gardnerella vaginalis Haemophilus ducreyi HHV-1 & 2 (Herpes Simplex) Lactobacillus crispatus Lactobacillus gasseri Lactobacillus iners Lactobacillus jensenii Megasphaera Type 1 & 2 Mobiluncus curtisii Mobiluncus mulieris Mycoplasma genitalium Mycoplasma hominis Neisseria gonorrhoeae Prevotella bivia Staphylococcus aureus Strep. agalactiae (Group B) Treponema pallidum Trichomonas vaginalis Ureaplasma urealyticum <b>ICD 10 CODES</b> N76.0 Acute vaginitis N77.1 Vaginitis, vulvitis, & vulvovaginitis B37.3 Candidiasis of vulva & vagina Z30.9 Encounter for contraceptive management SPECIMEN SOURCE: <input type="checkbox"/> Rectal Swab <input type="checkbox"/> Stool Specimen Swab <input type="checkbox"/> Other:	<input type="checkbox"/> STI Atopobium vaginae Chlamydia trachomatis Gardnerella vaginalis Haemophilus ducreyi HHV-1 & 2 (Herpes Simplex) Neisseria gonorrhoeae Treponema pallidum Trichomonas vaginalis <b>ICD 10 CODES</b> N76.0 Acute vaginitis N89.8 Other specified noninflammatory disorders of vagina R36.9 Urethral discharge unspecified Z30.9 Encounter for contraceptive management SPECIMEN SOURCE: <input type="checkbox"/> Urine <input type="checkbox"/> Swab	<input type="checkbox"/> Candida Candida albicans Candida dubliniensis Candida glabrata Candida krusei Candida lusitanae Candida parapsilosis Candida tropicalis <b>ICD 10 CODES</b> N76.0 Acute vaginitis N89.8 Other specified noninflammatory disorders of vagina SPECIMEN SOURCE: <input type="checkbox"/> Urine <input type="checkbox"/> Swab
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*alt well-pay patient, please run COVID-19 only, not COVID respiratory Lite.*

**PLEASE INDICATE IF YOUR PATIENT HAS TAKEN ANTIBIOTICS IN THE PAST 72 HOURS:  YES  NO**