DOCTORS ON DUTY
Salinas Valley Memorial Healthcare System

COVID19 Screening Questionnaire

Patient: ______________________________ Date of Birth: ____________
Address____
Phone: _______________________ **Email:** ________________________

Please check the box next to any symptoms that you have experienced in the past 7 days.

- ☐ Congestion or runny nose
- ☐ Cough
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Fever or chills
- ☐ Headache
- ☐ Muscle or body aches
- ☐ Nausea or vomiting
- ☐ New loss of taste or smell
- ☐ Shortness of breath or difficulty breathing
- ☐ Sore throat
- ☐ No Symptoms

Date Symptoms Started:_____________________

Have you been within 6 feet of a person with a lab-confirmed case of COVID-19 for at least 5 minutes, or had direct contact with their mucus or saliva, in the past 14 days?

☐ Yes ☐ No ☐ Possibly Date of last known/possible contact: ________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMAION

I herby authorize the release of medical information contained in this report.

Patient or Guardian Signature: ______________________________________

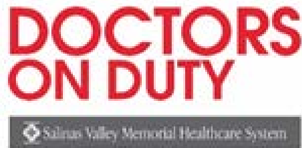
For Office Use Only

Rapid COVID-19 Test Results:

☐ Positive ☐ Negative

☐ Send Out PCR

Provider Signature: ________________________ Date: ________________
Notes:____



Acknowledgement of Privacy Practices

Date:
Patient Name:
DOB:

Privacy Official, 100 Wilson Rd, Ste 100, Monterey, CA 93940 Phone: (831) 649-1000

I hereby acknowledge that I received a copy of this medical office's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ____________________________________ **Date:** __________________________

Print Name: _________________________________

If not signed by the patient, please indicate your relationship with the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

I identify the following individuals as being involved in my care and/or payment of my care. I authorize my healthcare provider, or representative, to discuss any healthcare and/or financial information with the following individuals.

Name	Relationship	Phone

Signed: ____________________________________ Date: ___________________________