CompuNet CLINICAL LABORATORIES

# Patient Demographics—all information must be printed

**SECTION A—completed by patient**

**Name**: _____ **DOB** _____/_____/_____

**Residing street address**: _____

**City**: _____ **State** _____ **Zip Code** _____ **County**_____

**Gender** Male Female **Patient Phone (include area code):**_____

**Do you have insurance?** YES NO

Relationship to insured _____

Insurance Carrier Name: _____

Name of Policy Holder:_____ Insurance Group #:(if on card)_____

Insurance Member ID#/Policy #:_____

**Car:** Color: _____Make _____ Model _____

1. **Collection for procedure/surgery** YES NO If yes—procedure date _____

2. **Air travel within 72 hrs.** YES NO

**Please complete required Center for Disease Control (CDC) questions. (Circle answer):**

| | | |
|---|---|---|
| 3. Are you a healthcare worker with direct patient contact? | Yes | No |
| 4. Are you a first responder with direct citizen contact? | Yes | No |
| 5. Are you symptomatic for COVID? | Yes | No |
| 6. Are you pregnant? | Yes | No |
| 7. Are you a resident of a congregate living facility? | Yes | No |
| 8. Is this your first COVID test? | Yes | No |
| 9. Are you hospitalized? | Yes | No |

**SECTION B -completed by registration/collectors** **PPN initials _____** **CCL Tech Code _____**

Patient section is complete _____ (if incomplete- have patient complete missing information)

Test order is based on CDC pandemic & Public Health Emergency guidelines.

See COVID Collection Guide on test ordering.

**Section C – reviewed by collector with the patient at time of collection**

**Confirm name and DOB with patient prior to collection**

**Show patient collection container /patient confirm name and DOB are correct**