St. Joseph's Health

Date _____ Unit_____

EMPLOYEE COVID TESTING

NAME_____ DOB#_____

ADDRESS_____City_____Zip Code _____NJ

PHONE #_____ _____

LANGUAGE_ ☐ English ☐ Spanish ☐ Other_____ RACE_____

Sex- ☐ Male ☐ Female Martial Status ☐ Married ☐ Divorce ☐ Single ☐ Widow

INSURANCE ☐PRIVATE ☐CHARITY CARE ☐ SELF-PAY ☐St. Joseph's Employee

E-mail address: _____@_____.COM

EMERGENCY CONTACT NAME: _____

RELATIONSHIP ☐ Spouse ☐other_____ **PHONE _____**

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- **1ST COVID TEST ☐ YES ☐ NO**
- **COVID EXPOSURE ☐ YES ☐ NO**
- **EMPLOYED IN HEALTHCARE ☒ YES ☐ NO**
- **HOSPITALIZED FOR COVID ☐ YES ☐ NO**
- **GROUP HOME RESIDENT☐ YES ☐ NO**
- **PREGNANT ☐ YES ☐ NO ☐ N/A**
- **TESTED POSITIVE before ☐ YES ☐ NO**
- **COVID symptoms less than 5 days ☐ YES ☐ NO**
- **COVID Symptoms as per CDC ☐ YES ☐ NO *Fever, cough, shortness of breath, loss of taste or smell, sore throat, nausea, vomiting, etc.***

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Informed Consent for COVID-19 Testing

Please read carefully the following informed consent:

1- I consent to taking COVID-19 PCR by nasal or Nasopharyngeal swab test.
2- I authorize my test results to be disclosed to the county, state, and/or to any other government entity as may be required by law.
3- I acknowledge that a positive test results is an indication that I must self-isolate to avoid infecting others.

4- I have been informed about the test purpose, procedures, possible effects and risks.
5- I voluntarily agree to be tested for COVID-19

Name of person completing form_____

Patient/Guardian name: _____ **Verbal Consent** ☐ __ Date:_____

Medicare Entitlement- Medicare A and B (blue and red card alone)

- **Are you entitled to Medicare based on Age? ☐ YES ☐ NO**
- **Are you entitled to Medicare based on Disability ☐ YES ☐ NO**
- **Are you entitled to Medicare based on End Stage Renal Disease ☐ YES ☐ NO**
- **Are you receiving Black Lung (BL) benefits? ☐ YES ☐ NO**
- **Are you entitled to be part by a government program such as research grant? ☐ YES ☐ NO**
- **Has the Department of Veterans Affairs agreed to pay for the care at this facility? ☐ YES ☐ NO**
- **Is this visit associated with a work injury/illness? ☐ YES ☐ NO**
- **Is this visit associated with a non-work injury/illness? ☐ YES ☐ NO**

Group Health Plan (GHP) information with Patient as Subscriber

Are you currently employed?

☐ **Not currently not employed**
☐ **No never employed**
☐ **No, retired**
☐ **Yes, currently employed**

Group Health Plan (GHP) information with Spouse as Subscriber

If married, is your spouse currently employed?

☐ **Not currently not employed**
☐ **No never employed**
☐ **No, retired**
☐ **Yes, currently employed**