Riverview Health COVID-19 Screening Form

Patient Information			
Last Name:	First Name:	MI:	Date of birth
Street Address:	City:		Zip:
Sex: ☐ Male ☐ Female	Race:	Ethnicity:	Phone:

Collection Questions	
Purpose of testing:	Are you employed in a healthcare setting?
Is this your first COVID-19 test?	Are you pregnant?
Signature of participant (legal guardian's signature needed if participant is under age 18)	
X	Date:

RIVERVIEW HEALTH EMPLOYEE USE ONLY

Lab: *Order COVID PCR test as DTC test*

Updated 4/7/2021