Fill out this form in its entirety.

University of Arkansas Fort Smith
COVID - 19 TEST REQUEST FORM

Once form and collection are complete, scan form to ADHADMISSIONS@BAPTIST-HEALTH. ORG prior to delivering specimens to the hospital.

CLIENT INFORMATION (** REQUIRED FIELDS)

LAST NAME **	FIRST NAME**	MIDDLE INITIAL	DATE OF BIRTH** MM/DD/YYYY)	SSN**

STREET ADDRESS	SEX** MALE FEMALE	PHONE NUMBER

CITY	STATE	ZIP CODE	EMAIL ADDRESS

RACE	ETHNICITY
☐ WHITE	☐ HISPANIC
☐ BLACK OR AFRICAN AMERICAN	☐ NON HISPANIC
☐ AMERICAN INDIAN/NATIVE ALASKAN	☐ UNKNOWN
☐ ASIAN	
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER	
☐ OTHER	

ORDERING PHYSICIAN DR. AMANDA NOVACK

Submitter Name	UAFS - UNIVERSITY OF ARKANSAS AT FORT SMITH
Contact Person, email, phone	Lee Krehbiel, LEE.KREHBIEL@UAFS.EDU, 479-788-730
Address, City, State, Zip	5210 Grand Ave., Ste. 258, Ft. Smith, AR 72904

EPIDEMIOLOGY INFORMATION - MARK ALL THAT APPLY (** REQUIRED FIELDS)

Have you had contact with a confirmed case of Covid-19?**

☐ YES ☐ NO

Date of Onset of Symptoms:** MM/DD/YYYY)

Current Symptoms**

- ☐ None/Asmptomatic
- ☐ Chills
- ☐ Fever
- ☐ Muscle Aches
- ☐ Headache
- ☐ Cough
- ☐ Shortness of breath
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Sore Throat
- ☐ Vomiting

CDC Questionnaire:

Are you a healthcare worker?	☐ Yes	☐ No
Are you currently hospitalized?	☐ Yes	☐ No
Are you currently in the ICU?	☐ Yes	☐ No
Are you living in congregate care setting? (nursing home, homeless shelter,prison)	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Is this the your first Covid-19 Test?	☐ Yes	☐ No
Was other testing performed?	☐ Yes	☐ No
What were the results of that testing?		
Do you have any underlying medical conditions?	☐ Yes	☐ No

If Yes, please list:

I hereby authorize Baptist Health to disclose my COVID test result to the educational institution indicated on this form. I understand COVID is considered a communicable disease. This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by sending written notice the HIM Department at Baptist Health Medical Center Little Rock. I understand this authorization is voluntary and I may refuse to sign. I understand that once my information is released pursuant to this authorization it is no longer covered by HIPAA and may be further disclosed.

DONOR SIGNATURE TO RELEASE RESULTS:**

DATE OF SIGNATURE **

INSURANCE INFORMATION (** REQUIRED FIELDS)

PRIMARY INSURANCE COMPANY & PHONE NUMBER	SECONDARY INSURANCE COMPANY & PHONE NUMBER

PRIMARY INSURANCE ADDRESS **	CITY, STATE ZIP **	SECONDARY INSURANCE ADDRESS**	CITY, STATE, ZIP**

POLICY NUMBER	SUSCRIBER NAME AND DOB IF DIFFERENT FROM PT	POLICY NUMBER	SUSCRIBER NAME AND DOB IF DIFFERENT FROM PT

TEST REQUISITION INFORMATION (** REQUIRED FIELDS)

DATE COLLECTED **		TIME COLLECTED **		AM or PM ☐ ☐	SPECIMEN TYPE** circle one)	☐ Nasal Swab	NP Swab ☐

REQUESTOR'S NAME	NAVEEN PATIL, MD with the Arkansas Department of Health

Updated 08/09/2021