COVID-19 Test Request Form

Patient Information

Last Name:_____________________________First Name:_____________________MI: _____

DOB (MM/DD/YYYY):_____________________ Patient Phone Number: _____________________

Gender: ☐ Male ☐ Female Race:_______________ Ethnicity: ___________________

Home Street Address: ____

City: ___________________________ State: ____________ Zip Code: _____________

Parent/Guardian Name (if applicable): ____

Vaccinated: ______________________________Work Location:_______________________________

Symptoms Onset/ Exposure Date: __________________________________

Pregnant (Circle One): ____Yes ____ No

Have you been tested before (Circle One): ____Yes ____No If yes, provide date:_____________

Healthcare Worker (Circle One): ______Yes _____No

Current symptoms (check all that apply)

☐ Fever ☐ Cough ☐ Sore throat ☐ Fatigue ☐ Shortness of breath ☐ Congestion

☐ GI Issues ☐ Headaches ☐ Body Aches ☐ Sweats ☐ Loss of Taste/Smell ☐ Chills

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Send completed form to dohsrqcovid19@flhealth.gov. If unable to send form, call **941-861-2941.**