PHSC
PRIMARY HEALTH SERVICES CENTER

PATIENT'S CONSENT FORM

Name:	Date of Birth: (MM/DD/YY)	Age:	Chart Number:
Address:	City:	State:	Zip:
Email Address:	SS#:	Sex: ☐ Male ☐ Female	
Home Phone:	Mobile Phone No.:	Veteran Status: ☐ Veteran ☐ Not a Veteran	

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widower

Insurance Type:
- ☐ Medicaid
- ☐ Medicare
- ☐ Medicaid/Medicare
- ☐ Private

Race: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Also check below
☐ Black ☐ White ☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race
☐ Race Unreported

Number in Household	Monthly Income: $
Emergency Contact Person:	Relationship:	Phone Number:

CONSENT TO TREAT/PROCESS CLAIMS: I do hereby authorize PHSC or any member of their staff, under the direct supervision of appropriate licensed personnel, to provide such medical services to patients as he or she may deem reasonable and necessary to treat me, or my minor child, for any illness, condition, or disease which I am or may be afflicted.

RELEASE OF MEDICAL RECORDS: I authorize the release of my medical records to my family physician and/or to my insurance carrier to process any and all claims. And I authorize the release of medical records from other physicians to assist in my treatment.

LABORATORY SERVICES: Please be advised that if Laboratory tests are ordered or collected that our outside laboratory will bill you for all laboratory work. If any charge went towards your insurance, it will be billed to the party (Secondary insurance/patient/patient guarantor).

ADVANCE DIRECTIVES: It is the policy of PHSC as a primary care site NOT to honor any Advance Directives a patient may possess. A minimal of basic life support efforts will be initiated by staff and EMS will be activated. The patient may invoke his/her Advance Directives after being transferred from PHSC to the nearest tertiary care site.

PATIENT RIGHTS: I have received a copy of PHSC's Notice of Privacy Practices, which makes me aware of my privacy rights and HIPAA.

Housing Status:
☐ Public Housing ☐ Own a Home ☐ Family Justice/Well Springs ☐ Rent ☐ Other

☐ Homeless (If yes, please put check mark on current situation:
☐ Transitional shelter ☐ Streets ☐ Doubled-up (Living with someone else)

Signature of Patient/Responsible Person *X*	Date:
PHSC Witness *X*	Date:

PHSC
PRIMARY HEALTH SERVICES CENTER • ADMINISTRATIVE OFFICE
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INFORMED CONSENT TO PARTICIPATE IN TELEMEDICINE SERVICES

I understand that I will be receiving health care services through interactive video and/or audio equipment. I understand that at this time, there are no known risks involved in my receiving services through telemedicine and that these services are confidential and my privacy will be carefully maintained. I understand that these services will be delivered through encrypted /HIPAA-compliant videoconferencing that is as equally secure as all electronic medical communication and health records.

I understand that I will be informed of all participants in both the originating site/clinic and the distant site. I understand that my participation in telemedicine is voluntary, but that telemedicine will significantly increase my access to services. I understand that I may refuse to participate or decide to stop participating at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record.

I hereby consent to participate in receiving medical services by telemedicine under the terms of service described above. I understand this document will become a part of my medical record.

☐ I agree to participate in and receive medical services by telemedicine.

☐ I choose not to participate in medical services by telemedicine.

_____ _____
Patient Printed Name Date

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Signature Date

Patient Name: _____ Medical Record: _____

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Patient first name _____ Patient last name _____ Date of birth (MM/DD/YYYY): ____/_____/_____

……PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC……

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Reporting jurisdiction: _____ Case state/local ID: _____
Reporting health department: _____ CDC 2019-nCoV ID: _____
Contact ID [a]: _____ NNDSS loc. rec. ID/Case ID [b]: _____

a. Only complete if case-patient is a known contact of prior source case-patient. Assign Contact ID using CDC 2019-nCoV ID and sequential contact ID, e.g., Confirmed case CA102034567 has contacts CA102034567 -01 and CA102034567 -02. [b]For NNDSS reporters, use GenV2 or NETSS patient identifier.

Interviewer information

Name of interviewer: Last _____ First_____

Affiliation/Organization: _____ Telephone _____ Email _____

Basic information

What is the current status of this person?
- ☐ PUI, testing pending*
- ☐ PUI, tested negative*
- ☐ Presumptive case (positive local test), confirmatory testing pending†
- ☐ Presumptive case (positive local test), confirmatory tested negative†
- ☐ Laboratory-confirmed case†

*Testing performed by state, local, or CDC lab.
†At this time, all confirmatory testing occurs at CDC

Report date of PUI to CDC (MM/DD/YYYY):
____/_____/_____

Report date of case to CDC (MM/DD/YYYY):
____/_____/_____

County of residence: _____
State of residence: _____

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/ Latino
- ☐ Not specified

Sex:
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Other

Race (check all that apply):
- ☐ Asian
- ☐ Black
- ☐ White
- ☐ Other, specify: _____
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Unknown

Date of birth (MM/DD/YYYY): ____/_____/_____
Age: _____
Age units(yr/mo/day): _____

Date of first positive specimen collection (MM/DD/YYYY):
____/_____/_____
☐ Unknown ☐ N/A

Did the patient develop pneumonia?
☐ Yes ☐ Unknown ☐ No

Did the patient have acute respiratory distress syndrome?
☐ Yes ☐ Unknown ☐ No

Did the patient have another diagnosis/etiology for their illness?
☐ Yes ☐ Unknown ☐ No

Did the patient have an abnormal chest X-ray?
☐ Yes ☐ Unknown ☐ No

Was the patient hospitalized?
☐ Yes ☐ No ☐ Unknown

If yes, admission date 1
___/___/___ (MM/DD/YYYY)
If yes, discharge date 1
__/___/____ (MM/DD/YYYY)

Was the patient admitted to an intensive care unit (ICU)?
☐ Yes ☐ No ☐ Unknown

Did the patient receive mechanical ventilation (MV)/intubation?
☐ Yes ☐ No ☐ Unknown
If yes, total days with MV (days)
_____

Did the patient receive ECMO?
☐ Yes ☐ No ☐ Unknown

Did the patient die as a result of this illness?
☐ Yes ☐ No ☐ Unknown

Date of death (MM/DD/YYYY):
____/_____/_____
☐ Unknown date of death

Symptoms present during course of illness:
- ☐ Symptomatic
- ☐ Asymptomatic
- ☐ Unknown

If symptomatic, onset date (MM/DD/YYYY):
____/_____/_____
☐ Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY):
____/_____/_____
☐ Still symptomatic ☐ Unknown symptom status
☐ Symptoms resolved, unknown date

Is the patient a health care worker in the United States? ☐ Yes ☐ No ☐ Unknown
Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? ☐ Yes ☐ No ☐ Unknown
In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):
- ☐ Travel to Wuhan
- ☐ Travel to Hubei
- ☐ Travel to mainland China
- ☐ Travel to other non-US country specify:_____
- ☐ Household contact with another lab-confirmed COVID-19 case-patient
- ☐ Community contact with another lab-confirmed COVID-19 case-patient
- ☐ Any healthcare contact with another lab-confirmed COVID-19 case-patient ☐ Patient ☐ Visitor ☐ HCW
- ☐ Animal exposure
- ☐ Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology
- ☐ Other, specify:_____
- ☐ Unknown

If the patient had contact with another COVID-19 case, was this person a U.S. case? ☐ Yes, nCoV ID of source case: _____ ☐ No ☐ Unknown ☐ N/A

Under what process was the PUI or case first identified? (check all that apply): ☐ Clinical evaluation leading to PUI determination
☐ Contact tracing of case patient ☐ Routine surveillance ☐ EpiX notification of travelers; if checked, DGMQID_____
☐ Unknown ☐ Other, specify:_____

CDC 2019-nCoV ID: _____ Form Approved: OMB: 0920-1011 Exp. 4/23/2020

Human Infection with 2019 Novel Coronavirus
Person Under Investigation (PUI) and Case Report Form

Symptoms, clinical course, past medical history and social history

Collected from (check all that apply): ☐ Patient interview ☐ Medical record review

During this illness, did the patient experience any of the following symptoms?	Symptom Present?
Fever >100.4F (38C)[c]	☐Yes ☐No ☐Unk
Subjective fever (felt feverish)	☐Yes ☐No ☐Unk
Chills	☐Yes ☐No ☐Unk
Muscle aches (myalgia)	☐Yes ☐No ☐Unk
Runny nose (rhinorrhea)	☐Yes ☐No ☐Unk
Sore throat	☐Yes ☐No ☐Unk
Cough (new onset or worsening of chronic cough)	☐Yes ☐No ☐Unk
Shortness of breath (dyspnea)	☐Yes ☐No ☐Unk
Nausea or vomiting	☐Yes ☐No ☐Unk
Headache	☐Yes ☐No ☐Unk
Abdominal pain	☐Yes ☐No ☐Unk
Diarrhea (≥3 loose/looser than normal stools/24hr period)	☐Yes ☐No ☐Unk
Other, specify:_____	

Pre-existing medical conditions? ☐ Yes ☐ No ☐ Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	☐Yes	☐No	☐Unknown	
Diabetes Mellitus	☐Yes	☐No	☐Unknown	
Cardiovascular disease	☐Yes	☐No	☐Unknown	
Chronic Renal disease	☐Yes	☐No	☐Unknown	
Chronic Liver disease	☐Yes	☐No	☐Unknown	
Immunocompromised Condition	☐Yes	☐No	☐Unknown	
Neurologic/neurodevelopmental/intellectual disability	☐Yes	☐No	☐Unknown	(If YES, specify) _____
Other chronic diseases	☐Yes	☐No	☐Unknown	(If YES, specify) _____
If female, currently pregnant	☐Yes	☐No	☐Unknown	
Current smoker	☐Yes	☐No	☐Unknown	
Former smoker	☐Yes	☐No	☐Unknown	

Respiratory Diagnostic Testing

Test	Pos	Neg	Pend.	Not done
Influenza rapid Ag ☐ A ☐ B	☐	☐	☐	☐
Influenza PCR ☐ A ☐ B	☐	☐	☐	☐
RSV	☐	☐	☐	☐
H. metapneumovirus	☐	☐	☐	☐
Parainfluenza (1-4)	☐	☐	☐	☐
Adenovirus	☐	☐	☐	☐
Rhinovirus/enterovirus	☐	☐	☐	☐
Coronavirus (OC43, 229E, HKU1, NL63)	☐	☐	☐	☐
M. pneumoniae	☐	☐	☐	☐
C. pneumoniae	☐	☐	☐	☐
Other, Specify:_____	☐	☐	☐	☐

Specimens for COVID-19 Testing

Specimen Type	Specimen ID	Date Collected	State Lab Tested	State Lab Result	Sent to CDC	CDC Lab Result
NP Swab			☐		☐	
OP Swab			☐		☐	
Sputum			☐		☐	
Other, Specify: _____			☐		☐	

Additional State/local Specimen IDs: _____ _____ _____ _____ _____