**This clinic will see patients who screen positive for symptoms compatible with COVID-19 and provide assessment, testing and treatment as required. We do not accept walk-ins, asymptomatic patients or patients who have recently had a negative COVID-19 swab and have a family physician. We do not see patients younger than 1 year old.**

**PLEASE INCLUDE THE MOST UP TO DATE CONTACT INFORMATION FOR PATIENT, ALSO INCLUDE A COPY OF THE PATIENT’S CPP IF AVAILABLE**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED CONTACT#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH CARD#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLACE PATIENT LABEL HERE WITH MOST UP TO DATE INFORMATION

Check all that apply:

[ ]  Fever of 37.8 degrees or higher [ ]  Myalgias

[ ]  Shortness of Breath [ ]  Sore throat and/or pain swallowing

[ ]  Cough (new or worsening) [ ]  Change or loss of sense of taste/smell

[ ]  Nausea/Vomiting, diarrhea, abdominal pain [ ]  Chills

[ ]  Fatigue, lethargy, malaise [ ]  Decreased or lack of appetite

**COVID-19 Vaccination Status:** [ ]  **one dose only** [ ]  **two doses** [ ]  **Not Vaccinated**

Additional Comments:

**IMPORTANT INFORMATION NEEDED TO COMPLETE REFERRAL:**

PROVIDER’S FULL NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BACKLINE or CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OFFICE ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_