



# Yankton County Emergency Medical Services

## Yankton County COVID-19 Quick Test Form

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ First Responder Affiliation: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Symptom Information:

Is the patient symptomatic: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Symptoms:

- |   |  |
|---|--|
| <input type="checkbox"/> Fever; highest: _____    | <input type="checkbox"/> Shortness of breath or difficulty breathing |
| <input type="checkbox"/> Cough                    | <input type="checkbox"/> Fatigue                                     |
| <input type="checkbox"/> Headache                 | <input type="checkbox"/> Muscle or body aches                        |
| <input type="checkbox"/> Sore throat              | <input type="checkbox"/> Loss of taste or smell                      |
| <input type="checkbox"/> Congestion or runny nose | <input type="checkbox"/> Nausea or vomiting                          |
| <input type="checkbox"/> Diarrhea                 |  |

### Official use only:

Specimen Collection Date: \_\_\_\_\_ Time: \_\_\_\_\_

Specimen Source: Nasal                      Type of Lab: Antigen Test for SARS-CoV-2

Test Results: Positive   Negative

**Must Bring with you to Testing Site**