COVID-19 ISOLATION SITE REGISTRATION

Referral received ☐

Name - Referral Hospital/clinic/agency		
Name - Referring Physician/Care-Provider		
Name - Primary Guest (First and Last)		Date of Birth (month/day/year)
Street Address	City, State, Zip	
Cell Phone	Other Phone	Email
Does primary guest speak English? If no, what is Primary Language?	Name of person with primary guest who speaks English?	Relationship to primary guest?
Method of Transportation (Vehicle/bus/bike/walk)	If by Vehicle, provide License Plate No. and State	

Family Member Information (For families who are staying together with primary guest at this site)		
Name – First, Last	Age	Relationship to Primary Guest

Questions:

Are you required by law to register with a state or local government agency?	☐ Yes	☐ No
Are you a veteran or active military?	☐ Yes	☐ No
If you are taking any medications, or use medical supplies, do you have them with you?	☐ Yes	☐ No
Do you have dietary restrictions or allergies to food or medications?	☐ Yes	☐ No
Do you have any physical or mental health needs, a disability, or other condition(s) about which you are concerned? If **yes**, briefly explain what services you need?	☐ Yes	☐ No

If there are family members who will be staying with primary guest, ask if they have any of the above concerns.
(Reception Desk: Note comments on a separate log)

SIGNATURE – Isolation Site Coordinator	**Print Name**
Name of Isolation Site	Address/Room