Public Health Department Referral Form for COVID-19 Testing
Fax: (805)781-5543

Referring doctor's name: _____

Referring doctor's phone: _____ Referring doctor's fax: _____

Patient name: _____ Patient's DOB: _____

Patient phone: _____

Patient address: _____
Street City State Zip

Symptoms: ☐ Cough

☐ Fever

☐ Shortness of breath

☐ Fatigue

Contact with known case of COVID-19? ☐ Yes ☐ No

Tests already performed?
Influenza: ☐ Yes ☐ No Result: _____ Respiratory Pathogen Panel: ☐ Yes ☐ No Result: _____

Is patient a healthcare worker? ☐ Yes ☐ No Brief job description/facility? _____

Do you want us to test for COVID-19? ☐ Yes ☐ No

Other Comments: