



Churchill County Public Health Department
485 West B Street, Ste. 105
Fallon, NV 89406
(775)423-6695 option # 2

**PLEASE FAX PATIENT HISTORY FORM TO: 775-423-8057 or
Email to: Churchillcovid@churchillcounty.org**

**** PLEASE CALL (775)423-6695, OPTION 2 AND CONFIRM RECEIPT BY CCPH**

***** REFERRING PHYSICIAN TO COMPLETE AND ATTACH TO ORDER *******

PATIENT DEMOGRAPHICS

DATE SUBMITTED: _____
PATIENT NAME: _____
IF MINOR: PARENT / GUARDIAN NAME: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE NUMBER: _____ EMAIL ADDRESS: _____
DATE OF BIRTH: ____ / ____ / ____

PHYSICIAN / REFERRAL INFORMATION

PRIMARY PHYSICIAN: _____
FACILITY NAME: _____
PHYSICIAN DIRECT CONTACT PHONE NUMBER: _____
REFERRING DOCTOR, IF DIFFERENT: _____
REFERRING DOCTOR CONTACT PHONE NUMBER: _____

MEDICAL HISTORY

LAST DOCTOR OR ER VISIT: _____
KNOWN REACTIONS TO VACCINE(S): _____
MEDICAL HISTORY: _____
VACCINATED: _____ DATE OF FINAL SERIES DOSE: _____
CONFIRMED COVID POSITIVE: _____ DATE LAB COMPLETED: _____ TESTING FACILITY NAME: _____
SYMPTOM ONSET DATE: _____
SYMPTOMS: _____

Date:		Phone Number:	
Physician Name		Physician Fax Number	
Physician Signature:			

CHURCHILL COUNTY PUBLIC HEALTH ONLY

DATE PATIENT HISTORY AND ORDER RECEIVED: _____ RECEIVED BY: _____
PATIENT CONTACTED DATE: _____ TIME: _____
TREATMENT APPROVED AND SCHEDULED FOR : _____ IF DENIED, REASON: _____
RL REFERRAL DATE AND TIME: _____ CASE CLOSED, DATE DN TIME: _____