

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

Please complete all fields on this form. Incomplete forms will be denied.

Referring doctor or supervisor name: _____

Referring doctor or supervisor phone: _____

Referring doctor or supervisor fax: _____

Referring doctor or supervisor email: _____

Person Completing This Form: _____ Phone: _____

Patient Name: _____ Patient DOB: _____

Check here if client consents to receive COVID-19 Test Results via Text Message

Patient Mobile Phone: _____ Secondary Phone: _____

Patient address: _____
Street City State Zip

Place of Work: _____

Symptoms: Cough Shortness of breath
 Fever Fatigue
 Other: _____

Contact with known case of COVID-19? Yes
 No

Please indicated the patient's field of work:

Healthcare Long-term Care Homeless Shelters Corrections (Prison/Jail)
 First Responder Water / Wastewater Public Transportation Public Utility
 Veterinary Services Postal Workers City Public Works Agriculture
 Other: _____

Other Comments:

Please note: The Public Health Department does not provide COVID-19 testing for the purposes of pre-operative clearance.