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

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 ☐ Headache ☐ Loss of taste/smell
☐ Fever ☐ Fatigue ☐ Muscle aches ☐ Runny nose
☐ Diarrhea ☐ Vomiting/Nausea ☐ Chills/rigors ☐ Abdominal Pain
☐ No symptoms
☐ 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: _____

Is the patient of Hispanic, Latino/a, or Spanish origin?
☐ Yes ☐ No ☐ Don't Know / Not Sure

Which one or more of the following would you say is the patient's race? (Check all that apply)
☐ African American / Black ☐ American Indian / Alaska Native
☐ Asian ☐ Pacific Islander
☐ White ☐ Other:_____

Around when did the patient start feeling sick? (Leave blank if asymptomatic)

Other Comments: