Coquille Valley Hospital

940 East 5th Street, Coquille, Oregon 97423
Phone: 541-396-3101

PLACE PATIENT STICKER HERE
Patient Name_____
DOB: _____
MED REC #: _____
Physician: _____

CONDITIONS of CARE OUTPATIENT

Conditions of Admission

Authorization for treatment and hospital services - I authorize the doctor and others designated by such doctor to perform medical and /or surgical procedures and treatment at Coquille Valley Hospital and authorize the hospital to provide hospital services as authorized by such doctor or persons designated or appointed by such doctor.

Personal valuables and drugs – The hospital maintains safekeeping of money and valuables, and it is agreed that the hospital shall not be liable for the loss or damage to any money or other property, which has not been deposited, with the hospital for safekeeping. Patients are not permitted to have drugs in their possession, which have not been prescribed for use in the hospital.

Assignment of insurance benefits – The undersigned hereby assigns to Coquille Valley Hospital and authorizes direct payment to the hospital any insurance, Medicare or other benefits not to exceed the hospital's regular charges or hospital services.

Release of information – The hospital is authorized to release such information, including electronic health information, concerning this hospitalization as may be necessary for the completion of insurance, Medicare or other claims for reimbursement.

Responsibility for hospital charges – In consideration of the hospital and medical services to the patient, the undersigned (whether patient, parent, or personal representative) agrees that all charges for hospital services will be paid upon presentment of a statement of charges or as otherwise agreed by the hospital. The undersigned also agrees that if the account is placed in the hands of any attorney, or other agency, for collection, the hospital will be entitled to reasonable fees.

_____

_____

The undersigned certifies that he/she has read the foregoing, and is the patient or is duly authorized by the patient as patient's agent to execute the above and accept terms.

Patient to Initial Applicable Box:

YES	NO	
☐	☐	I have given accurate information regarding my Medicare Benefits.
☐	☐	I have been informed of my Patient Bill of Rights, Visitation rights, and responsibilities.

YES	DECLINED	
☐	☐	Copy provided to the patient?

_____ _____ _____

Patient/Parent/Legal Guardian Date Time

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940 East 5th Street, Coquille, Oregon 97423
Phone: 541-396-3101 | Fax 541-396-7374

COVID-19 TESTING – PATIENT QUESTIONNAIRE

First Name: _____ **Last Name:** _____ **Sex:** **M** **F**

DOB: _____ **County of Primary Residence:** _____ **Zip:** _____

Do you have any of the following symptoms of COVID-19?

☐ **Cough** ☐ **Fever > or = 100.3F** ☐ **Shortness of breath** ☐ **Fatigue** ☐ **Headache** ☐ **Diarrhea**	☐ **Feeling feverish** ☐ **Chills** ☐ **Difficulty breathing**	☐ **Muscle pain** ☐ **Loss of sense of taste** ☐ **Loss of sense of smell**	☐ **Sore throat** ☐ **Nasal congestion** ☐ **Nasal discharge** ☐ **Nausea** ☐ **Vomiting**

Do you live or work in a congregate setting (e.g. correctional facility, LTCF, shelter)? ***Yes*** ***No***

If yes, what is the name of the facility? _____

Have you been notified by a contact tracer that you are a close contact of a known COVID-19 case within the last 14 days? ***Yes*** ***No***

Please proceed to the Race, Ethnicity, Language, and Disability (REALD) Form to complete this questionnaire. The questions on the REALD form are optional and your answers are confidential. When complete, please return the form to the nurse or registration staff member.

For Office Use Only:

Patient Clinical Status:

- ☐ Inpatient
- ☐ Outpatient
- ☐ Healthcare Worker
- ☐ Staff
- ☐ Volunteer
- ☐ Other: _____

Place Patient Sticker Here

Form Compliant with OAR 333-018-0016: Oregon Health Authority - Division 18: Reporting of COVID-19 Related Tests Results, Cases and Deaths

Oregon Department of Human Services

Race, Ethnicity, Language, and Disability (REALD)

Oregon Health Authority

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact _____ at _____

Today's Date: _____ Medical record number (*if applicable*): _____

First Name: _____ Middle Initial: ____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

_____

2. Which of the following describes your **racial or ethnic identity**? Please check **ALL** that apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories
- ☐ Other *(please list)*
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?
- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ I do not have just one primary racial or ethnic identity.
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one category above.
- ☐ Don't know
- ☐ Don't want to answer

(To be filled in by agency or clinic staff)

Agency or clinic: **Agency staff or provider name or ID:**

Phone: **Address:**

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Language (*Interpreters are available at no charge*)

4a. What language or languages do you **use at home**? _____

Skip to question 7 if you indicated English only

4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?

_____

4c. In what language do you want us to **write** to you? _____

5a. Do you need or want an **interpreter** for us to communicate with you?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

☐ Spoken language interpreter
☐ American Sign Language interpreter
☐ Other ***(please list)***: _____
☐ Deaf Interpreter for DeafBlind, additional barriers, or both
☐ Contact sign language (PSE) interpreter

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)		Yes	***If yes**, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
7.	Are you **deaf** or do you have **serious difficulty hearing**?						
8.	Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?						
	Please stop now if you/the person is under age 5						
9.	Do you have **serious difficulty walking or climbing stairs**?						
10.	Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?						
11.	Do you have **difficulty dressing or bathing**?						
12.	Do you have **serious difficulty learning how to do things most people your age can learn**?						
13.	Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?						
	Please stop now if you/the person is under age 15						
14.	Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?						
15.	Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?						

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