Diagnostic Testing Eligibility Pre-Screening Questionnaire

1. If you have any of the below severe symptoms highlighted in **bold**, seek emergency medical care immediately and **<u>DO NOT</u>** complete the remainder of the questionnaire:

DO YOU HAVE:	YES	NO
Difficulty breathing?		
Persistent pain or pressure in the chest?		
New confusion?		
Inability to wake or stay awake?		
Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone?		

2. If you answer "YES" to any of the following, you are <u>NOT</u> eligible for flu and/or strep testing under GIANT/MARTIN'S Pharmacy's Diagnostic Testing Program. Please see your primary care physician or other healthcare provider.

PLEASE	ANSWE	ER ALL QUESTIONS BELOW:	YES	NO
Α.	. Are you under 5 years of age?			
В.	Are yo medica	u under 19 years of age and taking long-term aspirin or salicylate-containing ations?		
C.	Are yo	u pregnant or within 2 weeks after giving birth?		
D.	Are you currently on supplemental oxygen therapy or have a condition which requires oxygen therapy? Examples include but are not limited to COPD, emphysema, cystic fibrosis, congestive heart failure, sleep apnea.			
E.				
F.	treatm include	have an immunocompromising condition caused by a medical condition or ent which may result in moderate to severe immunocompromise? Examples but are not limited to: Active cancer treatment for tumors or cancers of the blood		
	b.	Receipt of an organ transplant and taking medicine to suppress the immune system		
	С.	Receipt of a stem cell transplant within the last 2 years or taking medicine to suppress the immune system		
	d.	Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)		
	e.	Advanced or untreated HIV infection		
	f.	Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response.		