

# COVID-19 Testing

Steps to take while you wait for and after you get test results.



Marshfield Clinic  
Health System

## Protect yourself and others.

- Wash your hands often with soap and water for at least 20 seconds.
- Do not spend time with people who are sick.
- Stay at least 6 feet from others, even if you are feeling well.
- Try not to touch your eyes, nose and mouth if you haven't washed your hands.
- Clean all high-touch surfaces every day.
- Cover your mouth and nose with a tissue when you cough or sneeze, or use the inside of your elbow.
- Wear a mask or face covering when you are around others.

## Take the following steps.

### If you are not feeling well or have been exposed to COVID-19:

- Follow instructions given while you wait for your results
- If you are a health care worker or first responder, let your workplace know you are being tested.
- If you are a household member of a student, ask the student's school district about their policies for household members' quarantine guidance.

### If you are feeling well:

- Follow best practices listed above to protect yourself and others. If you have been exposed to COVID-19, please follow instructions given.
- If you had a COVID-19 test for an upcoming procedure, quarantine until time of procedure.
- If you are a health care worker or first responder, ask your manager about any work or patient care restrictions until you know your test results.

## Watch for symptoms.

- Keep track of any new symptoms and temperature. (Use the 14-day symptom tracker).
- Contact your primary care provider if symptoms worsen or if you have questions.
- Even if you don't have symptoms, you can get others sick.

## Call 911 or go to an Emergency Department if you have emergency warning signs:\*

- o Struggling to breathe
- o Bluish lips or face
- o Constant chest pain or pressure
- o Feeling dizzy or lightheaded all the time
- o Acting confused
- o Difficult to wake up
- o Slurred speech (new or getting worse)
- o New seizure or seizures that won't stop

\*Note: This list does not include all emergency warning signs. Call 911 for any medical emergencies.

An **exposure** is if you were within 6 feet of an infected person for at least 15 minutes starting from 48 hours before illness onset until the time the infected person was isolated.

**Isolation** separates a person because they are known or believed to be infected with a communicable disease.

**Quarantine** separates a person believed to be exposed to a communicable disease but not yet symptomatic.

## COVID-19 Test Results

**Regardless of whether you test positive or negative, you need to continue to protect yourself and others. Each situation can vary. Follow instructions from your health care provider and public health.**

Based on public health's assessment of your situation, their guidance may differ from what your health care provider has recommended. If this is the case, follow public health's recommendation.

### What if your test comes back positive?

#### Follow these steps to start home isolation:

- Do not have contact with others. Everyone who lives in your household should stay home.
- Do not go to work. Let your employer know you tested positive for COVID-19.
- Do not go to the hospital unless you have a medical emergency. Most people who have COVID-19 have minor symptoms like fever and cough and are able to get better on their own at home.
- Watch for symptoms. Contact your doctor right away if you have any emergency warning signs.
- Get rest and drink plenty of fluids.
- Over-the-counter medications that lessen symptoms of fever or cough may help. Talk to your provider about additional medications or treatments.
- Even if you don't have symptoms, you might get others sick.

### When is home isolation over?

#### All three items below must be met to stop isolation.

- Isolate for 5 days from symptom onset.
- If you have no symptoms or your symptoms are resolving after 5 days, you can end isolation.
- Continue to wear a well-fitting mask around others for 5 additional days (10 days total).

### What if your COVID-19 test comes back NEGATIVE?

- You most likely do not have COVID-19 at this time.
- You could have been exposed to COVID-19 at some point and not enough time has passed for the test to pick it up. You may test positive at a later date.
- You need to continue to practice protective measures to help keep yourself and others from getting sick.
- Follow instructions from your doctor and your state and local health departments.

### Are you a close contact of someone with COVID-19?

If your negative test (PCR or antigen) was collected on day 5 of your quarantine you can end quarantine early. Continue to monitor for symptoms for the full 14 days after your last close contact with a COVID-19 case. Continue to wear a mask around others for at least 5 days from negative test.

**If you have been fully vaccinated against COVID-19**, you do not have to quarantine, however, you should get tested 5 days after exposure and wear a mask in a public indoor settings for 14 days or until you receive a negative COVID-19 test result. Continue to wear a mask around others for at least 5 days from negative test.

### Are you in close contact of someone with COVID-19?

Anyone who has been exposed should get tested 5 days after exposure.

If you have been fully vaccinated against COVID-19, including a booster dose, you do not have to quarantine but you should wear a mask around others for 10 days.

If you have not been vaccinated, have not received a booster dose, you should quarantine for 5 days and wear a mask for an additional 5 days.

**COVID-19**

**14-day Symptom Tracker**

Name \_\_\_\_\_ Medical Health Number \_\_\_\_\_

**Instructions:**

- Put current date in the space provided for the next 14 days.
- Take your temperature twice a day; once in the morning (a.m.) and once in the evening (p.m.). A fever is defined by CDC as a temperature equal to or greater than 100.0°F.
- Check Yes or No to the symptoms in each column for the day.
- Do not leave any spaces blank. If symptoms are present or become worse, contact your primary care provider or dial 911 for emergent medical assistance.

Symptoms	Dates (month/day) – Answer yes or no for each date													
	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Do you have a fever ≥ 100.0° F* (37.8° C) or chills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a new cough not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have new shortness of breath or difficulty breathing not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have new fatigue not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have new muscle or body aches not due a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a new headache not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a new loss of taste or smell not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a new sore throat not due to chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have new nasal congestion and/or runny nose not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have new nausea or vomiting not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have new diarrhea not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have new abdominal pain not due to a chronic condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

