SARS-CoV-2 (COVID-19) Requisition

All information below is **required** by the U.S. Health and Human Services (HHS) Department and Centers for Disease Control (CDC).

ACCESSION LABEL

CLINICAL PATHOLOGY LABORATORIES
A Sonic Healthcare Company

COVID-19 FORM 01

PATIENT INFORMATION

Patient Name

Gender ◯ Female ◯ Male

_____ _____ _____
Last Name *First Name* *M.I.*

Patient Address

_____
City/State *Zip Code*

Date of Birth _____ Patient I.D. *(optional)* _____ Patient Phone # _____ – _____ – _____

PATIENT RACE *(REQUIRED BY HHS AND CDC)*

◯ American Indian or Alaskan Native (AI)
◯ Asian (AS)
◯ Black or African American (B)
◯ Native Hawaiian or Other Pacific Islander (PI)
◯ White (W)
◯ Multiple/Other (O)

PATIENT ETHNICITY *(REQUIRED BY HHS AND CDC)*

◯ Hispanic/Latino (H) ◯ Non-Hispanic/Latino (N) ◯ Unspecified/Not Given/Refused (U)

COVID-19 CLINICAL HISTORY *(REQUIRED BY HHS AND CDC)*

First Test?	◯ YES	◯ NO	◯ UNKNOWN
Employed in Healthcare?	◯ YES	◯ NO	◯ UNKNOWN
Symptomatic as defined by CDC?	◯ YES	◯ NO	◯ UNKNOWN
If YES, then date of symptom onset (mm/dd/yy):	☐☐/☐☐/☐☐		
Hospitalized for COVID-19?	◯ YES	◯ NO	◯ UNKNOWN
ICU for COVID-19?	◯ YES	◯ NO	◯ UNKNOWN
Resident in congregate care setting?	◯ YES	◯ NO	◯ UNKNOWN
Pregnant?	◯ YES	◯ NO	◯ UNKNOWN

HOW TO PROPERLY FILL OUT THIS FORM

CORRECT WAY:

● • Fill circle all the way
• No marks outside of the lines
• Use a black ink pen

UNACCEPTABLE WAYS:

⊖ ∅ ⊗ ✓ ⊘

ACCOUNT INFORMATION

Account #:

Client Name:

Client Address:

Ordering Provider

_____

Ordering Provider Phone #

_____

COLLECTION DETAILS

Date Collected _____ Time Collected _____

BILLING AND INSURANCE

◯ Client Bill ◯ Insurance Bill *(attach copy of card)* ◯ Uninsured Patient *(complete section below for HRSA coverage)*

ICD-10 Diagnosis _____ ICD-10 Diagnosis _____ ICD-10 Diagnosis _____ ICD-10 Diagnosis _____

◯ Z11.52 Encounter for screening for COVID-19
◯ Z20.822 Contact with and (suspected) exposure to COVID-19
◯ Z86.16 Personal history of COVID-19

INSURANCE INFORMATION *(IF APPLICABLE)*

Primary Insurance Name _____ Name of Policy Holder _____ Member ID _____ Group # _____

UNINSURED PATIENT INFORMATION

Driver License #/State: _____/_____ SSN (if DL/State not applicable): _____

TESTING OPTIONS (PCR)

◯ 7305 SARS-CoV-2 by NAAT (PCR, TMA)
◯ 3571 COVID-19/Influenza A/B by NAAT (upper respir. specimens only)

Source for test code selected:

◯ Anterior Nares (AN) ◯ Tracheal Aspirate (TASP) ◯ Nasopharyngeal (NP)
◯ Oropharyngeal (OP) ◯ Nasal Turbinate (NT) ◯ Sputum (SP)
◯ Bronchoalveolar Lavage (BAL)

TESTING OPTIONS (Antibody)

COVID-19 Disease, Nucleocapsid

◯ 7304 SARS-CoV-2 Total Ab ◯ 7301 SARS-CoV-2 IgG Ab

COVID-19 Disease, Spike/Receptor Binding Domain (Immune Response)

◯ 3608 SARS-CoV-2 Total Ab, S Protein