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).

COVID-19 FORM 01

PATHOLOGY LABORATORIES
A Sonic Healthcare Company

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 Signature

_____

Ordering Provider Phone #

_____

COLLECTION DETAILS

Date Collected _____ Time Collected _____

BILLING AND INSURANCE

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

ICD-10 Signs & Symptoms

_____

_____

_____

_____

_____

Please code ICD-10 at highest level specifically as documented in patient chart:

- ○ Z20.822 Contact with and (suspected) exposure to COVID-19
- ○ Z86.16 Personal History of COVID-19
- ○ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
- ○ Z11.52 Encounter for screening for COVID-19 (asymptomatic)*
- ○ Z11.59 Encounter for screening for other viral diseases (asymptomatic)*
- ○ M35.81 Multisystem Inflammatory Syndrome (MIS)
- ○ M35.89 Other specified systemic involvement of connective tissue
- ○ J12.82 Pneumonia due to COVID-19

** Test ordered for screening purposes may not be covered by some health plans.*

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)

- ○ 39429 SARS-CoV-2 by RT-PCR (PCR, TMA)
- ○ 39439 COVID 19 / INFLUENZA A/B, NAAT

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)

- ○ 39433 SARS-COV-2 IGG (ABBOTT)
- ○ 39432 SARS-COV-2 IGG (EUROIMMUN)
- ○ 39434 SARS-COV-2 ANTIBODIES (ROCHE)
- ○ 39444 SARS-COV-2 S TOTAL ANTIBODY (SPIKE S ANTIBODY) (ROCHE)

ACCESSION LABEL

[22407]