

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 Clinical Laboratory

PATIENT INFORMATION

Patient Name _____ Gender _____
Last Name _____ First Name _____ M.I. _____ Female Male
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) Native Hawaiian or Other Pacific Islander (PI)
 Asian (AS) White (W)
 Black or African American (B) 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 M35.81 Multisystem Inflammatory Syndrome (MIS)
 Z86.16 Personal History of COVID-19 M35.89 Other specified systemic involvement of connective tissue
 Z20.828 Contact with and (suspected) exposure to other viral communicable diseases J12.82 Pneumonia due to COVID-19
 Z11.52 Encounter for screening for COVID-19 (asymptomatic)*
 Z11.59 Encounter for screening for other viral diseases (asymptomatic)*

*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 39429 and 39439:

- Anterior Nares (AN) Nasal Turbinate (NT) Nasopharyngeal (NP)

Source for Test Code 39429 only:

- Saliva (Saliva Direct™ Compatible Collection Kit)

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