

# 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. \_\_\_\_\_  
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

## BILLING AND INSURANCE

- Client Bill     Insurance Bill (attach copy of card)     Patient Bill

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

<input type="radio"/> Z20.822	Contact with and (suspected) exposure to COVID-19	<input type="radio"/> M35.81	Multisystem Inflammatory Syndrome (MIS)
<input type="radio"/> Z86.16	Personal History of COVID-19	<input type="radio"/> M35.89	Other specified systemic involvement of connective tissue
<input type="radio"/> Z20.828	Contact with and (suspected) exposure to other viral communicable diseases	<input type="radio"/> J12.82	Pneumonia due to COVID-19
<input type="radio"/> Z11.52	Encounter for screening for COVID-19 (asymptomatic)*		
<input type="radio"/> 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 # \_\_\_\_\_

## 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)

## 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 \_\_\_\_\_

## TESTING OPTIONS (Antibody)

- 39434 SARS-COV-2 ANTIBODIES (ROCHE)  
 39444 SARS-COV-2 S TOTAL ANTIBODY (SPIKE S ANTIBODY) (ROCHE)  
 39447 SARS CORONAVIRUS 2 IGG ANTIBODY

ACCESSION LABEL

Revision Date: 08/22

1310601