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

_____ _____ _____ ○ 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

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 # _____

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)

- ☐ 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

[31060]

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