

PHYSICIAN'S INFORMATION

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PATIENT'S INFORMATION

NAME (LAST, FIRST)		M.I.
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DOB (MM/DD/YY)	PHONE
EMAIL		PATIENT ID#
ADDRESS		
CITY	STATE	ZIP

SPECIMEN COLLECTION
BILLING INFORMATION

DATE	<input type="checkbox"/> BILL PATIENT <input type="checkbox"/> BILL CLIENT <input type="checkbox"/> BILL INSURANCE	INSURANCE CO. NAME	SUBSCRIBER MEMBER#	GROUP#
TIME <input type="checkbox"/> AM <input type="checkbox"/> PM		INSURANCE ADDRESS	CITY	STATE

COVID-19 TESTS

LEGEND: RF - Refrigerated | RT - Room Temperature

RT	94547-7 <input type="checkbox"/> COVID TOTAL AB IgG/IgM	Specimen: SST
RF	94534-5 <input type="checkbox"/> SARS-Cov2 RT-PCR	Specimen: SWAB

PLEASE ANSWER THE FOLLOWING QUESTIONS

FIRST TEST? <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYED IN HEALTHCARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER RACE _____
SYMPTOMATIC? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES" DATE: _____	
HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ICU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
RESIDENT IN CONGREGATE CARE SETTING? <input type="checkbox"/> YES <input type="checkbox"/> NO	ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC
	COLLECTION SITE <input type="checkbox"/> ANTERIOR NARES <input type="checkbox"/> MID-TURBINATE <input type="checkbox"/> NASOPHARYNGEAL

DIAGNOSES (ICD-10 CODES)

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SIGNATURE _____

DATE _____