Intermountain Healthcare
Intermountain Central Laboratory

# 2019 NOVEL CORONAVIRUS (SARS-CoV-2, COVID-19) QUALITATIVE PCR OUTPATIENT ORDER and PATIENT HISTORY FORM

Client/Clinic Name:_____ Ordering Provider full name & ID: _____

***Entire form must be complete for testing***

| **PATIENT INFORMATION** | | |
|---|---|---|
| FULL LEGAL NAME (Last, First) | | DATE OF BIRTH |
| STREET: | | |
| CITY: | STATE & ZIP: | PHONE NUMBER<br>Cell phone:<br>Alternative: |
| Email address: | | |

| **BILLING INFORMATION** ☐ Encounter face sheet attached | |
|---|---|
| Primary Insurance: | Secondary Insurance: |
| Policy Number: | Policy number: |
| Subscriber Name: | Subscriber Name: |
| **DIAGNOSES** (if applicable): | |

**CLINICAL INFORMATION**

| PATIENT LOCATION | SYMPTOMS | EXPOSURE CATEGORY | ASYMPTOMATIC INDICATIONS |
|---|---|---|---|
| ☐ Clinic<br>☐ Employer/Business Client<br>☐ SNF/Nursing Home<br>☐ Patient/Resident<br>☐ Employee/Caregiver*<br>☐ Urgent Care<br>☐ Connect Care/Drive Through<br>☐ Other:_____<br><br>**Billing Locations (if applicable)**<br>Bill Patient:<br>Bill Client:<br>Employee:<br><br>*Signed HIPAA release required | ☐ Fever<br>☐ Cough<br>☐ Shortness of breath<br>☐ Body Aches<br>☐ Decreased smell<br>☐ Runny/stuffy nose<br>☐ Sore Throat<br>☐ Diarrhea | ☐ Close contact with confirmed case of COVID- 19<br>☐ Healthcare worker with high-risk exposure<br>☐ Special populations (eg. Immunocompromised, skilled nursing facility, pregnant women, homeless, etc)<br>☐ Close contact with person under investigation for COVID-19<br>☐ No known exposure or epidemiologic risk | ☐ Transplant Donor/Recipient<br>☐ Woman in Labor/Imminent Delivery/Post-Partum<br>☐ Lives in High-Density Area (SNF, shelter, etc)<br>☐ Travel<br>☐ High Risk Public Health Risk per Intermountain Infectious Disease Provider _____ |

**SPECIMEN INFORMATION****

| SPECIMENS COLLECTED | | COLLECTION DATE & TIME | COLLECTED BY |
|---|---|---|---|
| ☐ Nasopharyngeal swab | ☐ Sputum | | |
| ☐ Endotracheal aspirate | ☐ BAL | | |
| ☐ Saliva | ☐ Other:_____ | | |

****SPECIMEN REQUIREMENTS**

| | |
|---|---|
| **SPECIMENS** | **Saliva (2 options)**<br>• Spectrum saliva kit, 2 mL<br>• Saliva without additives ("Neat") in a sterile conical tube, 2 mL<br>**Nasopharyngeal swab**<br>• Flocked swab in viral transport media (VTM, UTM or M4)<br>**Lower respiratory tract specimens** (If feasible)<br>• BAL, sputum, tracheal aspirate<br>• 1-3 mL<br>• Sterile, preservative-free container<br>**Nasopharyngeal or oropharyngeal aspirates or washes** (Accepted, but not preferred)<br>• 1-3 mL<br>• Sterile, preservative-free container |
| **TRANSPORT** | Refrigerated |
| **STABILITY** | Room temperature: 4 hours, saliva: 7 days<br>Refrigerated: 3 days, saliva: 7 days<br>Frozen (-70 C): 30 days |
| **UNACCEPTABLE** | Nasal or oral specimens |
| **PERFORMED** | Daily. NOTE: Patients will be prioritized if the number of orders exceeds testing capacity. |

***Note:*** *The use of this form implies that the ordering provider has confirmed with the patient that the patient has consented to receiving electronic communication.*

*Intermountain Central Lab Use Only: If out-of-network insurance, register as Misc. Ins. for COV19 only.*