



Intermountain® 2019 NOVEL CORONAVIRUS (SARS-CoV-2, COVID-19) QUALITATIVE PCR PATIENT HISTORY FORM

Intermountain Central Laboratory

Please Fax to 385-297-2343

PATIENT INFORMATION			
LEGAL NAME		DATE OF BIRTH	
ORDERING PROVIDER INFORMATION			
PHYSICIAN/APP NAME		ADDRESS	PHONE NUMBER Daytime: After-hours:
Provider Signature:			
CONSULTATION ON ELIGIBILITY FOR TESTING			
CONSULTED WITH*		CONSULTANT PHYSICIAN'S NAME	DATE & TIME OF CONSULTATION
<input type="checkbox"/> SCORE/COVID-19 LINE/ID <input type="checkbox"/> OTHER <input type="checkbox"/> CONNECT CARE <input type="checkbox"/> NONE			
*It is extremely important to screen patients for testing until there are no further limitations on testing capacity. References to assist with risk assessment include: iCentra order algorithm, SCORE Line (801-50-SCORE – PROVIDERS ONLY), Connect Care (801- 442-4457), or the COVID Call Center (844-442-5224). UDOH COVID-19 Testing Evaluation Form (https://pubredcap.health.utah.gov/surveys/?s=RTMFDYK4TH) may also be useful. DO NOT REFER PATIENTS TO THE SCORE LINE.			
CLINICAL INFORMATION			
PATIENT LOCATION	SYMPTOMS	EXPOSURE CATEGORY	OTHER INDICATIONS
<input type="checkbox"/> ICU <input type="checkbox"/> Inpatient <input type="checkbox"/> SNF/Nursing Home <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Urgent Care <input type="checkbox"/> Connect Care/Drive Through <input type="checkbox"/> Clinic <input type="checkbox"/> Other:	<input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Body Aches <input type="checkbox"/> Decreased smell <input type="checkbox"/> Runny/stuffy nose <input type="checkbox"/> Sore Throat <input type="checkbox"/> Diarrhea <input type="checkbox"/> Unexplained ARDS	<input type="checkbox"/> Close contact with confirmed case of COVID-19 <input type="checkbox"/> Travel to high-risk geographic area within 14 days of symptom onset Area(s) visited: <input type="checkbox"/> Symptomatic healthcare worker with high-risk exposure <input type="checkbox"/> Special populations (e.g. Immunocompromised, skilled nursing facility, pregnant women, homeless, etc.) <input type="checkbox"/> Close contact with person under investigation for COVID-19 <input type="checkbox"/> No known exposure or epidemiologic risk	<input type="checkbox"/> Transplant Donor/Recipient <input type="checkbox"/> Woman in Labor/Imminent Delivery/Post-Partum <input type="checkbox"/> Lives in High-Density Area (SNF, shelter, etc) <input type="checkbox"/> High Risk Public Health Risk per Intermountain Infectious Disease Provider _____
***** STOP HERE IF SENDING PATIENT TO CURBSIDE CLINIC FOR SPECIMEN COLLECTION *****			
SPECIMEN INFORMATION**			
SPECIMENS COLLECTED		COLLECTION DATE & TIME	COLLECTED BY
<input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Sputum <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> BAL <input type="checkbox"/> Other:			
BILLING INFORMATION			
<input type="checkbox"/> Order placed in iCentra <input type="checkbox"/> Requisition attached <input type="checkbox"/> Encounter face sheet attached			
**SPECIMEN REQUIREMENTS			
SPECIMENS	<u>Nasopharyngeal swab</u> (Preferred) <ul style="list-style-type: none"> • Flocked swab in viral transport media (VTM, UTM or M4) <u>Lower respiratory tract specimens</u> (If feasible) <ul style="list-style-type: none"> • BAL, sputum, tracheal aspirate • 1-3 mL • Sterile, preservative-free container <u>Nasopharyngeal or oropharyngeal aspirates or washes</u> (Accepted, but not preferred) <ul style="list-style-type: none"> • 1-3 mL • Sterile, preservative-free container 		
TRANSPORT	Refrigerated		
STABILITY	Room temperature: 4 hours Refrigerated: 3 days Frozen (-70 C): 30 days		
UNACCEPTABLE PERFORMED	Nasal or oral specimens		
	Daily. NOTE: Patients will be prioritized if the number of orders exceeds testing capacity.		

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

COVID-19 Patient History
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