

**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 Cell phone: Alternative:
Email address:		

BILLING INFORMATION		<input type="checkbox"/> 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
<input type="checkbox"/> Clinic <input type="checkbox"/> Employer/Business Client <input type="checkbox"/> SNF/Nursing Home <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Employee/Caregiver* <input type="checkbox"/> Urgent Care <input type="checkbox"/> Connect Care/Drive Through <input type="checkbox"/> Other: _____ Billing Locations (if applicable) Bill Patient: Bill Client: Employee:	<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"/> Close contact with confirmed case of COVID-19 <input type="checkbox"/> Healthcare worker with high-risk exposure <input type="checkbox"/> Special populations (eg. 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"/> Travel <input type="checkbox"/> High Risk Public Health Risk per Intermountain Infectious Disease Provider _____
*Signed HIPPA release required			

SPECIMEN INFORMATION**			
SPECIMENS COLLECTED		COLLECTION DATE & TIME	COLLECTED BY
<input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> Saliva	<input type="checkbox"/> Sputum <input type="checkbox"/> BAL <input type="checkbox"/> Other: _____		

****SPECIMEN REQUIREMENTS**

SPECIMENS	<u>Saliva (2 options)</u> <ul style="list-style-type: none"> Spectrum saliva kit, 2 mL Saliva without additives ("Neat") in a sterile conical tube, 2 mL <u>Nasopharyngeal swab</u> <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, saliva: 7 days Refrigerated: 3 days, saliva: 7 days 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.