

Requisition for COVID testing with required HHS (Health and Human Services) AOE (Ask on Order Entry) fields

Fax to REC: (785) 505-5334
 REC phone: (785) 505-2880



Michael Thompson, M.D., Medical Director
 LMH Main Lab • 325 Maine St
 Lawrence, KS 66044
 Phone(785) 505-6179
 Fax(785) 505-5202

PATIENT INFORMATION																																																																																																																																																																																																																					
LAST NAME			FIRST NAME			SEX M F		DATE OF BIRTH																																																																																																																																																																																																													
SOCIAL SECURITY NUMBER — — —				PRIMARY PHONE ()																																																																																																																																																																																																																	
ADDRESS					CITY		STATE		ZIP																																																																																																																																																																																																												
INSURANCE / BILLING INFORMATION: attach front and back copies of insurance card to expedite registration																																																																																																																																																																																																																					
If you would like for REC Clinic to setup appointment with the patient please mark Yes and be sure to have up-to-date phone number above																																																																																																																																																																																																																					
YES <input type="checkbox"/>																																																																																																																																																																																																																					
If pre-procedure, please include procedure date: / /																																																																																																																																																																																																																					
DOCTOR / PRACTITIONER SIGNATURE					DATE																																																																																																																																																																																																																
					SIGNS & SYMPTOMS/ DX Fever (R50.9) _____ Dyspnea (R06.00) _____ Contact with and (suspected) exposure to other viral communicable diseases. (Z20.828) _____ Malaise (R53.81) _____ Sore Throat (J02.9) _____ Encounter for screening for other viral diseases. (Z11.59). Asymptomatic Screen _____ Loss of Taste/Smell (R43.0) _____ Rigors (R68.89) _____ Myalgia (M79.10) _____ Diarrhea (R19.7) _____ Cough (R05) _____ Other: _____																																																																																																																																																																																																																
										ORDERING PHYSICIAN (PLEASE PRINT)					<input type="checkbox"/> FAX <input type="checkbox"/> CALL #		COPIES TO:		<input type="checkbox"/> STAT <input type="checkbox"/> ASAP																																																																																																																																																																																																		
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 20%;">REASON FOR TESTING</th> <th style="width: 15%;">PRE OP</th> <th style="width: 5%;">CHECK</th> <th style="width: 5%;"></th> <th style="width: 5%;"></th> <th style="width: 15%;">HOSPITALIZED?</th> <th style="width: 5%;">YES</th> <th style="width: 5%;">CHECK</th> <th style="width: 5%;"></th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td>HCW OR FAMILY OF</td> <td></td> <td></td> <td></td> <td></td> <td>NO</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>INPATIENT</td> <td></td> <td></td> <td></td> <td></td> <td>UNKNOWN</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>ID APPROVED</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>OTHER-SCREEN</td> <td></td> <td></td> <td>7</td> <td>ICU</td> <td>YES</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>EMERG. SURGERY</td> <td></td> <td></td> <td></td> <td></td> <td>NO</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>MAB HIGH RISK</td> <td></td> <td></td> <td></td> <td></td> <td>UNKNOWN</td> <td></td> <td></td> </tr> <tr> <td>2</td> <td>SUSPECTED OR SCREEN</td> <td>SUSPECTED</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>SCREEN</td> <td></td> <td></td> <td>8</td> <td>RESIDES IN CONGREGATE CARE</td> <td>YES</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NO</td> <td></td> <td></td> </tr> <tr> <td>3</td> <td>FIRST TEST?</td> <td>YES</td> <td></td> <td></td> <td></td> <td></td> <td>UNKNOWN</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>NO</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>UNKNOWN</td> <td></td> <td></td> <td>9</td> <td>PREGNANT</td> <td>PREGNANT</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NOT PREG.</td> <td></td> <td></td> </tr> <tr> <td>4</td> <td>EMPLOYEED IN HEALTHCARE</td> <td>YES</td> <td></td> <td></td> <td></td> <td></td> <td>UNKNOWN</td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>NO</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>UNKNOWN</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>5</td> <td rowspan="3">SYMPTOMATIC (AS DEFINED BY CDC)</td> <td>YES</td> <td></td> <td></td> <td></td> <td colspan="4"> <input type="checkbox"/> CORONAVIRUS (COVID-19)SAR CoV-2 BY PCR <input type="checkbox"/> COVID ANTIGEN (POINT OF CARE)—RECOMMENDED TEST FOR POTENTIAL RE-INFECTION </td> </tr> <tr> <td></td> <td>NO</td> <td></td> <td></td> <td></td> <td colspan="4" rowspan="2">ADDITIONAL TESTS:</td> </tr> <tr> <td></td> <td>UNKNOWN</td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>DATE OF ONSET (IF APPLICABLE)</td> <td>/ /</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>											REASON FOR TESTING	PRE OP	CHECK			HOSPITALIZED?	YES	CHECK		1		HCW OR FAMILY OF					NO					INPATIENT					UNKNOWN					ID APPROVED										OTHER-SCREEN			7	ICU	YES					EMERG. SURGERY					NO					MAB HIGH RISK					UNKNOWN			2	SUSPECTED OR SCREEN	SUSPECTED										SCREEN			8	RESIDES IN CONGREGATE CARE	YES										NO			3	FIRST TEST?	YES					UNKNOWN					NO										UNKNOWN			9	PREGNANT	PREGNANT										NOT PREG.			4	EMPLOYEED IN HEALTHCARE	YES					UNKNOWN					NO										UNKNOWN								5	SYMPTOMATIC (AS DEFINED BY CDC)	YES				<input type="checkbox"/> CORONAVIRUS (COVID-19)SAR CoV-2 BY PCR <input type="checkbox"/> COVID ANTIGEN (POINT OF CARE)—RECOMMENDED TEST FOR POTENTIAL RE-INFECTION					NO				ADDITIONAL TESTS:					UNKNOWN					DATE OF ONSET (IF APPLICABLE)	/ /							
	REASON FOR TESTING	PRE OP	CHECK			HOSPITALIZED?	YES	CHECK																																																																																																																																																																																																													
1		HCW OR FAMILY OF					NO																																																																																																																																																																																																														
		INPATIENT					UNKNOWN																																																																																																																																																																																																														
		ID APPROVED																																																																																																																																																																																																																			
		OTHER-SCREEN			7	ICU	YES																																																																																																																																																																																																														
		EMERG. SURGERY					NO																																																																																																																																																																																																														
		MAB HIGH RISK					UNKNOWN																																																																																																																																																																																																														
2	SUSPECTED OR SCREEN	SUSPECTED																																																																																																																																																																																																																			
		SCREEN			8	RESIDES IN CONGREGATE CARE	YES																																																																																																																																																																																																														
							NO																																																																																																																																																																																																														
3	FIRST TEST?	YES					UNKNOWN																																																																																																																																																																																																														
		NO																																																																																																																																																																																																																			
		UNKNOWN			9	PREGNANT	PREGNANT																																																																																																																																																																																																														
							NOT PREG.																																																																																																																																																																																																														
4	EMPLOYEED IN HEALTHCARE	YES					UNKNOWN																																																																																																																																																																																																														
		NO																																																																																																																																																																																																																			
		UNKNOWN																																																																																																																																																																																																																			
5	SYMPTOMATIC (AS DEFINED BY CDC)	YES				<input type="checkbox"/> CORONAVIRUS (COVID-19)SAR CoV-2 BY PCR <input type="checkbox"/> COVID ANTIGEN (POINT OF CARE)—RECOMMENDED TEST FOR POTENTIAL RE-INFECTION																																																																																																																																																																																																															
		NO				ADDITIONAL TESTS:																																																																																																																																																																																																															
		UNKNOWN																																																																																																																																																																																																																			
	DATE OF ONSET (IF APPLICABLE)	/ /																																																																																																																																																																																																																			