St John's HEALTH

* A B C 1 2 3 4 5 *

COVID Order Form

Scheduling 739-7531
FAX - Patient orders to 877-205-2024

☐ Bill Patient
☐ MEDICARE ☐ Medicaid

Patient Name: _____
DOB: _____ M / F
Patient Phone Numbers: _____

Date Ordered: _____
For Service Date: _____
Ordering Physician: _____
Physician Signature: _____

MEDICARE/INSURANCE POLICY # (required): _____ **(You can also fax a demographic/face sheet)**

COVID TESTS

- ☐ COVID-19 Testing Send Out
- ☐ SARS-CoV-2 (COVID-19) PCR (GeneXpert)
- ☐ Respiratory Panel 2 w COVID-19 (BioFire)
- ☐ SARS-CoV-2 IgG, Qualitative (COVID-19) by CIA

CARES Act Required Questions

1. First test?	YES	NO	UNKNOWN
2. Employed in healthcare?	YES	NO	UNKNOWN
3. Symptomatic as defined by CDC?	YES	NO	UNKNOWN
3a. Date of Symptom Onset	DATE:_____		
4. Hospitalized?	YES	NO	UNKNOWN
5. ICU?	YES	NO	UNKNOWN
6. Resident in a congregate care setting?	YES	NO	UNKNOWN
7. Pregnant?	YES	NO	UNKNOWN

Additional Required Questions

Recent Travel? (Y/N/U)	YES	NO	UNKNOWN

Travel Location: _____

Employer: _____

ICD-10 /WRITTEN DIAGNOSIS

- ☐ **Z20.828** Exposure to Virus
- ☐ **R50.9** Fever, Unspecified
- ☐ **R05** Cough
- ☐ **R06.02** Shortness of Breath
- ☐ **R68.83** Chills
- ☐ **R52** Muscle Pain
- ☐ **R51** Headache
- ☐ **J02.9** Sore Throat
- ☐ **R43.9** Loss of Smell or Taste
- ☐ **R43.8** Loss of Smell AND Taste
- ☐ **U07.1** COVID-19
- ☐ **Z11.59** Screening

OTHER (Include Code & Diagnosis):

OTHER TESTS/COMMENTS: Consult online Test Directories and enter Test Number, Test Name or Test Code to ensure accuracy of order. For Online menu, specimen requirement, and interpretation see https://www.testmenu.com/sjmclab. If order not found refer to http://www.aruplab.com/