

SARS-CoV-2 (COVID-19) Requisition

All information below is **required** by the U.S. Health and Human Services (HHS) Department and Centers for Disease Control (CDC).

ACCESSION LABEL



EAST SIDE CLINICAL
LABORATORY

A Sonic Healthcare Company

PH: (401) 455-8400 | F: (401) 861-4229 | WWW.ESCLAB.COM
10 RISHO AVENUE EAST PROVIDENCE, RI 02914

PATIENT INFORMATION

Patient Name _____ Gender _____
Last Name _____ First Name _____ M.I. _____
Patient Address _____
City/State _____ Zip Code _____
Date of Birth _____ Patient I.D. (optional) _____ Patient Phone # _____

PATIENT RACE (REQUIRED BY HHS AND CDC)

- American Indian or Alaskan Native (AI) Native Hawaiian or Other Pacific Islander (PI)
 Asian (AS) White (W)
 Black or African American (B) Multiple/Other (O)

PATIENT ETHNICITY (REQUIRED BY HHS AND CDC)

- Hispanic/Latino (H) Non-Hispanic/Latino (N) Unspecified/Not Given/Refused (U)

COVID-19 CLINICAL HISTORY (REQUIRED BY HHS AND CDC)

- First Test? YES NO UNKNOWN
Employed in Healthcare? YES NO UNKNOWN
Symptomatic as defined by CDC? YES NO UNKNOWN
If YES, then date of symptom onset (mm/dd/yy): / /
Hospitalized for COVID-19? YES NO UNKNOWN
ICU for COVID-19? YES NO UNKNOWN
Resident in congregate care setting? YES NO UNKNOWN
Pregnant? YES NO UNKNOWN

HOW TO PROPERLY FILL OUT THIS FORM

CORRECT WAY:

- Fill circle all the way
- No marks outside of the lines
- Use a black ink pen

UNACCEPTABLE WAYS:



ACCOUNT INFORMATION

Account #:

Client Name:

Client Address:

Ordering Provider:

Ordering Provider Phone #

COLLECTION DETAILS

Date Collected

Time Collected

BILLING AND INSURANCE

- Client Bill Insurance Bill (attach copy of card) Uninsured Patient (complete section below for HRSA coverage)

ICD-10 Diagnosis _____ ICD-10 Diagnosis _____ ICD-10 Diagnosis _____ ICD-10 Diagnosis _____
 Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out
 Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
 Z11.59 Encounter for screening for other viral diseases (asymptomatic)

INSURANCE INFORMATION (IF APPLICABLE)

Primary Insurance Name _____ Name of Policy Holder _____ Member ID _____ Group # _____

UNINSURED PATIENT INFORMATION

Driver License # _____ State of Issuance _____

TESTING OPTIONS

- 17200 SARS-CoV-2 by NAAT (PCR, TMA)
Source: Anterior Nares (AN) Bronchoalveolar Lavage (BAL) Nasal Turbinate (NT) Nasopharyngeal (NP)
 Oropharyngeal (OP) Tracheal Aspirate (TASP) Sputum (SP)
 11357 SARS-CoV-2 Total Ab