

**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\***

Please Fax to **385-297-2343**

<b>PATIENT INFORMATION</b>			
FULL LEGAL NAME (Last, First)		DATE OF BIRTH	
STREET:			
CITY:	STATE & ZIP:	PHONE NUMBER	Cell phone:
Alternative:			
Email address:			
<b>BILLING INFORMATION</b> <input type="checkbox"/> Encounter face sheet attached			
Primary Insurance:		Secondary Insurance:	
Policy Number:		Policy number:	
Subscriber Name:		Subscriber Name:	
DIAGNOSES (if applicable):			
<b>CLINICAL INFORMATION</b>			
<b>PATIENT LOCATION</b>	<b>SYMPTOMS</b>	<b>EXPOSURE CATEGORY</b>	<b>ASYMPTOMATIC INDICATIONS</b>
<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: _____	<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 underinvestigation 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 _____
<b>Billing Locations (if applicable)</b> Bill Patient: Bill Client: Employee:  *Signed HIPPA release required			

<b>SPECIMEN INFORMATION**</b>			
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**

<b>SPECIMENS</b>	<b>Saliva (2 options)</b>
	<ul style="list-style-type: none"> <li>Spectrum saliva kit, 2 mL</li> <li>Saliva without additives ("Neat") in a sterile conical tube, 2 mL</li> </ul>
<b>TRANSPORT</b>	Refrigerated
	Room temperature: 4 hours, saliva: 7 days
<b>STABILITY</b>	Refrigerated: 3 days, saliva: 7 days
	Frozen (-70 C): 30 days
<b>UNACCEPTABLE</b>	Nasal or oral specimens
<b>PERFORMED</b>	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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