



Ordering Location Name: St. Claire HealthCare

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Race: \_\_\_\_\_ Language: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_

Guarantor: \_\_\_\_\_

Have you been around anyone that has COVID?  Yes  No

**TESTING**

Date of Collection: \_\_\_\_\_  SARS-CoV-2

- Specimen Type:  Nasopharyngeal with Liquid Amies
- Nasopharyngeal with VTM
- Nasopharyngeal with \_\_\_\_\_

**ICD-10 CODES (Check all that apply.)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> R05 Cough  | <input type="checkbox"/> R50.9 Fever unspecified       | <input type="checkbox"/> R06.02 Shortness of breath       |
| <input type="checkbox"/> R07.0 Pain in throat                                   | <input type="checkbox"/> R43.9 Loss of smell and taste | <input type="checkbox"/> M79.1 Muscle pain                |
| <input type="checkbox"/> R53.83 Other fatigue                                   | <input type="checkbox"/> R68.83 Chills (without fever) | <input type="checkbox"/> U07.01 COVID-19,virus identified |
| <input type="checkbox"/> Z03.818 Contact with and (suspected) exposure COVID-19 |  | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> Z86.19 Personal history of other infectious diseases   |  |   |

My signature authorizes the providing laboratory to perform the above check-marked test(s) for the ICD-10 condition(s) identified. I certify based upon this patient's history, symptoms, examination findings, and medical record that all ordered testes are medically necessary.

Physician Signature: Authorized on behalf of William Melahn, MD