

PLEASE PRINT CLEARLY – Fill out and Fax to: 508-519-6128

**Requisition for COVID Collection - only to be used for non-epic affiliated providers**

Patient Last Name:

First Name:

Address:

DOB:

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ X \_\_\_\_\_

Patient phone number:

Patient's Self-Reported Race(s) (Patient may select all that apply):

- American Indian or Alaska Native \_\_\_\_\_
- Asian \_\_\_\_\_
- Black or African American \_\_\_\_\_
- Native Hawaiian or Pacific Islander \_\_\_\_\_
- White \_\_\_\_\_
- Other \_\_\_\_\_
- Declined to Answer \_\_\_\_\_

Patient's Self-Reported Hispanic Indicator:

- Hispanic or Latino \_\_\_\_\_
- Not Hispanic or Latino \_\_\_\_\_
- Declined to Answer \_\_\_\_\_

Patient's Self-Reported Ethnicity or Ethic Background (i.e., American, Brazilian, Korean, etc.)

Declined to Answer \_\_\_\_\_

Sample Collection Date:

Insurance Company / Guarantor / Submitter (if paid by an Employer):

Sample Collection Time:

Referring Office Fax Number:

Direct Phone for Provider for Questions or Issues:

Ordering Provider:

Must provide one or more DX code:

- Z20.828: Contact with and suspected exposure to COVID 19 \_\_\_\_\_
- R05: Cough \_\_\_\_\_
- R06.02: Shortness of breath, or difficulty breathing \_\_\_\_\_
- R50.9: Fever (+100F), unspecified \_\_\_\_\_
- R68.83: Chills, without fever \_\_\_\_\_
- J02.9: Sore Throat \_\_\_\_\_
- M79.18: Muscle Pain \_\_\_\_\_
- G44.209: Headache, unspecified \_\_\_\_\_
- R43.0: New loss of taste or smell \_\_\_\_\_
- Z11.59 Screening \_\_\_\_\_

**Please check off test**

	TEST	MNEMONIC	SPEC TYPE
	COVID - 19 PCR (UMMHC)	LAB31815	Saliva Collection/Self E-Swab
	COVID- 19 PCR Pre-procedure (Asymptomatic)	LAB31822	Saliva Collection/Self E-Swab
	COVID-19 PCR Pre-Procedure (Symptomatic)	LAB31823	Saliva Collection/Self E-Swab
	COVID-19 PCR for Surveillance of Asymptomatic Patient	LAB32019	Saliva Collection/Self E-Swab