ACCESSION LABEL

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).

EAST SIDE CLINICAL LABORATORY

A Sonic Healthcare Company

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

PATIENT INFORMATION

Please send results to the following Email: ______________________

Patient Name

Last Name ______ First Name ______ M.I. ______

Gender: ○ Female ○ Male

Patient Address ______________________

City/State ______ Zip Code ______

Date of Birth ______ Patient I.D. *(optional)* ______ Patient Phone # ____ - ____ - ____

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 #: **32651**

Client Name: **TOWN OF COVENTRY - COVID ONLY (TOCO)**

Client Address: **40 RESERVOIR ROAD**
COVENTRY, RI 02816

PH: (401) 821 - 6866
F: (401) 826 - 3779

Requesting Provider:
HERBERT J. BRENNAN, DO (BREH)

Requesting Provider Phone #:
(401) 886 - 6000

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

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

○ 17110 SARS-CoV-2 by NAAT (PCR, TMA)

Source: ○ Anterior Nares (AN) ○ Nasal Turbinate (NT)
○ Oropharyngeal (OP) ● Nasopharyngeal (NP)

○ 11357 SARS-CoV-2 Total Ab