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.EASTSIDELAB.COM
10 RISHO AVENUE EAST PROVIDENCE, RI 02914

PATIENT INFORMATION

Please send results to the following Email: _____

Patient Name

_____ _____ _____ Gender ◯ Female ◉ Male

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)
◯ Asian (AS)
◯ Black or African American (B)
◯ Native Hawaiian or Other Pacific Islander (PI)
◯ White (W)
◯ 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 #: **32867**

Client Name: **TOWN OF CHARLESTOWN - COVID ONLY (TOCH)**

Client Address: **4891 OLD POST ROAD**
CHARLESTOWN, RI 02813

PH: (401) 364-3742
F: (401) 364-5438

Requesting Provider:
RYAN CARTER, MD (CARTRY)

Requesting Provider Phone #:
(401) 348-3325

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