SOUTHEASTERN PATHOLOGY
311 West 8th Street Rome, GA 30165
706-291-2430
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COVID-19 REQUISITION

Collection Date	Clinician	Office Location:

PATIENT

*Name (Last) _____ (First) _____ (MI) _____ PT ID # _____

*SSN _____ *Date of Birth _____ *Sex: ☐ M ☐ F

Race: ☐ American Indian/Alaska Native ☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Asian ☐ Other
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Mailing Address _____ City _____ State _____ Zip _____

Phone_____ Email _____

Test Code: **COVID19**

Test Name: **SARS CoV-2, RNA**

Bill To:☐ Insurance

☐ CARES Act (Self Pay Fund)

**** INCLUDE COPY OF INSURANCE CARD**

AND DRIVER'S LICENSE**

Reason For Test (Check one or more)

☐ Pre-Procedure (Z11.59)
☐ Possible Exposure (Z03.818)
☐ Travel (Z11.59)
☐ Individuals Testing Positive for COVID-19 (U07.1)
☐ Exposure to confirmed COVID19 patient (Z20.828)

1. First test? ☐ Y / ☐ N / ☐ U
2. Employed in healthcare? ☐ Y / ☐ N / ☐ U
3. Symptomatic as defined by CDC? ☐ Y / ☐ N / ☐ U; If yes, then Date of Symptom Onset: ___/___/____
4. Hospitalized? ☐ Y / ☐ N / ☐ U
5. ICU? ☐ Y / ☐ N / ☐ U
6. Resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting): ☐ Y / ☐ N / ☐ U
7. Pregnant? ☐ Y / ☐ N / ☐ U

SEP USE ONLY	RESULT	REPORTING
Collection Date:_____		Reported Date:_____
Collection Time:_____		Reported To:_____
Collected By:_____	Dr 05	Reported By:_____
Counseling By:_____ 99211	U0003	