SOUTHEASTERN PATHOLOGY
311 West 8th Street Rome, GA 30165
706-291-2430
800-225-8702
Fax: 706-290-0201
www.sepath.com

☐ Previous COVID-19 test through SEP?

# 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 (Attach Insurance Card)

☐ CARES Act (Uninsured Fund)**

**** REQUIRES SOCIAL SECURITY NUMBER AND/OR DRIVER'S LICENSE****

**Reason For Test (Check one or more)**

☐ Pre-Procedure (Z03.818)

☐ Exposure to Confirmed COVID-19 (Z20.822)

☐ Suspected exposure to COVID-19 (Z20.822)

☐ Travel-Rule Out Exposure (Z20.822)

☐ Positive for COVID19 currently (U07.1)

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
8. Fully vaccinated against COVID-19? ☐ Y / ☐ N / ☐ U

| SEP USE ONLY | RESULT | REPORTING |
|---|---|---|
| Collection Date:_____ | | Reported Date:_____ |
| Collection Time:_____ | Dr 05<br>U0003<br>U0005<br>G2023 | Reported To:_____ |
| Collected By:_____ | | Reported By:_____ |
| Counseling By:_____ | | Reported to GDH:_____ |

Edited on March 2021