Clinical Pathology Associates

Sars-CoV-2 (COVID-19) Requisition
All information below is required by the U.S. Health and Human Services Department and the Centers for Disease Control & Prevention.

COVID-19 Requisition Form

Patient Information

Patient Name: Gender
◯ Female ◯ Male
Last Name First Name MI

Patient Aaddress:

City / State Zip Code

Date of Birth: Patient ID (optional): Patient Phone #

Patient Race (Required by HHS & CDC)

◯ American Indian or Alaskan Native
◯ Native Hawaiian or Pacific Islander
◯ Asian
◯ Caucasian (White)
◯ Black or African American
◯ Multiple / Other

COVID-19 Clinical History (Required by HHS & CDC)

First Test:	◯ Yes	◯ No	◯ Unknown
Employed in Healthcare:	◯ Yes	◯ No	◯ Unknown
Symptomatic (as defined by CDC):	◯ Yes	◯ No	◯ Unknown
If Yes, onset date of symptoms (mm/dd/yy):			
Hospitalized for COVID-19:	◯ Yes	◯ No	◯ Unknown
ICU hospitiliazation for COVID-19:	◯ Yes	◯ No	◯ Unknown
Resident in congregate care setting:	◯ Yes	◯ No	◯ Unknown
Pregnant:	◯ Yes	◯ No	◯ Unknown

Patient Ethnicity (Required by HHS & CDC)

◯ Hispanic / Latino
◯ Non-Hispanic / Non-Latino
◯ Unspecified / Not Given / Refused

Account Information

Client Name:

Client Address:

Ordering Clinician Information

Ordering Clinician: Ordering Clinician Phone #:

Specimen Collection Information

Date Collecteed: Time Collected:

Insurance and Billing

◯ Bill Insurance (attach a copy of ins card) ◯ Client Bill ◯ Bill Patient ◯ Other:

ICD-10 Diagnosis code: ICD-10 Diagnosis code: ICD-10 Diagnosis code:

◯ Z11.52 Encounter for COVID 19 screening ◯ Z20.822 Suspected exposure to COVID-19 ◯ Z86.16 Personal histroy of COVID-19

Insurance Information (if applicable):

Primary Insurance: Policy Holder's Name: Member ID#: Group #":

Uninsured Patient Information:

Driver's License # / State: / SSN (if no Driver's License: