COVID-19 ORDER FORM

(INCLUDE WITH **ALL** COVID-19 ORDERS)

Patient ID

_____

Last Name First Name MI

_____

Date of Birth SS#

_____ _____

County of Residence Sex *(at birth)*

_____ _____

Street Address

_____

City State Zip

_____ _____ _____

Patient Phone Number

_____

DATE OF COLLECTION _____

SUBMITTER INFORMATION

Provider

_____

Mailing Address

_____

City State Zip

_____ _____ _____

Phone Number

_____

Fax Number

_____

SITE/SOURCE of SPECIMEN

☐ Nasopharyngeal

(At least 2 for all patients)

(Follow directions per media)

HEALTHCARE PROVIDER

Position: _____

Marshall Health or Mountain Health? _____

Other: _____

PATIENT LOCATION

_____ ICU

_____ Floor

COLLECTION SITE

_____ Drive through location

_____ CHH

_____ SMMC

_____ Other

_____

_____ Pre Op testing

EMERGENCY DEPARTMENT

_____ Home _____Admit Floor _____Admit ICU

_____ Law Enforcement/Congregant Living