PATHOLOGY CONSULTANTS OF NEW MEXICO

FOCUSED ON PRECISION

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COVID-19 TEST FORM

PATIENT/CASE INFORMATION

Patient	DOB	Sex	SSN

Address	City/State/Zip/County	Phone Number

Clinician	Collection Date

Procedure Performed at (please provide facility name)	Copy to (please provide physician or facility name)

Patient Email	Patient Signature

INSURANCE INFORMATION (please indicate if self pay)

Payor	ID/Group Number

Policyholder Name	Policyholder DOB

Claims Address

CARE STATUS - MUST CHECK APPLICABLE

- ☐ Patient is Hospitalized
  - ☐ ICU
  - ☐ Inpatient
- ☐ Patient is Pending Surgery
- ☐ Patient is Symptomatic
  - Onset Date: _____
- ☐ Patient is Asymptomatic

COLLECTION SOURCE

- ☐ Nasal Swab
- ☐ Oropharyngeal (OP)

ICD-10 CODING

- ☐ Z11.59, encounter for screening for other viral diseases
- ☐ Z20.828, exposure to confirmed case of COVID-19
- ☐ R06.02, shortness of breath
- ☐ Z03.818, suspected exposure to COVID-19
- ☐ R05, cough
- ☐ R50.9, fever - unspecified

ADDITIONAL INFORMATION

First COVID-19 Test: Y / N

Employed in Healthcare: Y / N

Resident in congregate care setting: Y / N

Pregnant: Y / N

Race/Ethnicity: _____