

## 2019 NOVEL CORONAVIRUS (SARS-CoV-2, COVID-19) QUALITATIVE PCR PATIENT HISTORY FORM

\*\*\* Testing will not be performed without this form. Complete all sections.\*\*\*

PATIENT INFORMATION			
LEGAL NAME		DATE OF BIRTH	
ORDERING PROVIDER INFORMATION			
PHYSICIAN/APP NAME		ADDRESS	PHONE NUMBER Daytime: after hours:
CONSULTATION ON ELIGIBILITY FOR TESTING			
CONSULTED WITH* <input type="checkbox"/> SCORE/COVID-19 LINE or ID <input type="checkbox"/> OTHER <input type="checkbox"/> CONNECT CARE <input type="checkbox"/> NONE		CONSULTANT PHYSICIAN'S NAME	DATE & TIME OF CONSULTATION
*Vetting criteria with UDOH COVID-19 Testing Evaluation Form ( <a href="http://pubredcap.health.utah.gov/surveys/?s=RTMFDYK4THN22">pubredcap.health.utah.gov/surveys/?s=RTMFDYK4THN22</a> ), SCORE Line (801-507-2673), Infectious Disease, or Connect Care (801-442-4457) is <b>encouraged</b> if decision for testing is unclear. Testing will have high priority when recommended by one of these resources. <b>DO NOT REFER PATIENTS TO THE SCORE LINE.</b>			
CLINICAL INFORMATION			
PATIENT LOCATION	SYMPTOMS	EXPOSURE CATEGORY	
<input type="checkbox"/> ICU <input type="checkbox"/> Inpatient <input type="checkbox"/> SNF/Nursing Home <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Urgent Care <input type="checkbox"/> Connect Care/Drive Through <input type="checkbox"/> Clinic <input type="checkbox"/> Drive Through (not referred/walkup) <input type="checkbox"/> Other:	<input type="checkbox"/> Severe pneumonia or ARDS <input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Dyspnea <input type="checkbox"/> Other: Duration of symptoms:	<input type="checkbox"/> Close contact with confirmed case of COVID-19 <input type="checkbox"/> Travel to high-risk geographic area within 14 days of symptom onset Area(s) visited: <input type="checkbox"/> Symptomatic healthcare worker with high-risk exposure <input type="checkbox"/> Special populations (e.g., immunocompromised, skilled nursing facility, pregnant women, homeless, etc.) <input type="checkbox"/> Close contact with person under investigation for COVID-19 <input type="checkbox"/> No known exposure or epidemiologic risk	
SPECIMEN INFORMATION**			
SPECIMENS COLLECTED <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Sputum <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> BAL <input type="checkbox"/> Other:		COLLECTION DATE & TIME	COLLECTED BY
BILLING INFORMATION			
<input type="checkbox"/> Order placed in iCentra <input type="checkbox"/> Requisition attached <input type="checkbox"/> Encounter face sheet attached			

### \*\*SPECIMEN REQUIREMENTS

<b>SPECIMENS</b>	<u>Nasopharyngeal swab</u> (Preferred) <ul style="list-style-type: none"> <li>Flocked swab in viral transport media (VTM, UTM or M4)</li> </ul> <u>Lower respiratory tract specimens</u> (if feasible) <ul style="list-style-type: none"> <li>BAL, sputum, tracheal aspirate</li> <li>1-3 mL</li> <li>Sterile, preservative-free container</li> </ul> <u>Nasopharyngeal or oropharyngeal aspirates or washes</u> (Accepted, but not preferred) <ul style="list-style-type: none"> <li>1-3 mL</li> <li>Sterile, preservative-free container</li> </ul>
<b>TRANSPORT</b>	Refrigerated
<b>STABILITY</b>	Room temperature: 4 hours Refrigerated: 3 days Frozen (-70 C): 30 days
<b>UNACCEPTABLE</b>	Nasal or oral specimens
<b>PERFORMED</b>	Daily. NOTE: Patients will be prioritized if the number of orders exceeds testing capacity.