Main Line Health Laboratories

Mainlinehealth.org/labs **1-484-580-4200** **2K-20** Rev. 8.20

Haverford College Student COVID testing
370 Lancaster Ave., Haverford, PA 19041
Tel. (610) 896-1089 daytime
(610) 417-2245 after hours
Fax 833-628-6670

Jonathan B. Stallkamp, MD

Provider Signature (Required)_____

PATIENT INFORMATION (Please print):.

_____
LAST NAME FIRST MI

DOB _____/ _____/ _____ GENDER AT BIRTH: M___ F___

TELEPHONE NUMBER: _____

_____
STUDENT HOME STREET ADDRESS

_____
CITY STATE ZIP

☐ **Uninsured – Bill to Haverford College**

☐ **Insurance coverage – complete information below**

_____
INSURED (SUSCRIBER / RESPONSIBLE PARTY) NAME AND DATE OF BIRTH IF NOT SELF

RELATIONSHIP OF PATIENT TO INSURED: ☐SELF ☐ SPOUSE ☐ DEPENDENT

INSURANCE: COMPLETE BELOW OR ATTACH A COPY OF THE STUDENT'S CURRENT MEDICAL INSURANCE CARD FRONT AND BACK

☐ AETNA PPO ☐ PERS CHOICE ☐ DVACO ☐ UNITED HEALTHCARE

☐ OTHER MEDICAL INS., NAME _____

_____
POLICY ID NUMBER GROUP NUMBER

Guarantor: Haverford College

INDICATE MEDICAL REASON FOR EACH AND ALL REQUESTED TESTS BELOW. ICD-10 CODING MUST BE PROVIDED. * * INDICATES MEDICARE LIMITED COVERAGE TEST(S).

ICD DX CODE ➔	Z11.59		
CODE(S) REQUIRED			

MICROBIOLOGY

☒ COVID-19 RNA BY PCR U0019

COMPLETE THE FOLLOWING INFORMATION REQUIRED AS BY THE DHHS:

Question	Answer – check one	Clarification
1. Is this the patient's first test?	☐ YES ☐ NO ☐ UNKNOWN	Is this the patient's first test for the condition of interest?
2. Is the patient employed in healthcare?	☐ YES ☐ NO ☐ UNKNOWN	E.G., First responders, front line clinicians, environmental staff, therapists, and those in direct contact with patients or in their location.
3. Is the patient symptomatic as defined by the CDC?	☐ YES ☐ NO ☐ UNKNOWN	Symptomatic per CDC guidance at the time of order for the reportable condition or illness.
a. If YES, then date of symptom onset	MM / DD / YEAR: ____ /____ / ____	
4. Is the patient hospitalized?	☐ YES ☐ NO ☐ UNKNOWN	Patient has been hospitalized for the reported illness/condition that this order has been placed for (suspected or diagnosed). When ordered during ER duration, the answer would be NO.
5. Is the patient in an intensive care unit (ICU)?	☐ YES ☐ NO ☐ UNKNOWN	Patient has been admitted to the ICU at any time during the encounter for the reportable illness/condition that this order has been placed for (suspected or diagnosed).
6. Is the patient in a congregate care setting?	☐ YES ☐ NO ☐ UNKNOWN	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 at the time of service where they normally live.
7. Is the patient pregnant?	☐ CURRENTLY PREGNANT ☐ POSSIBLE PREGNANCY ☐ NOT PREGNANT ☐ UNKNOWN	Current pregnancy status of the patient.
8. Patient Race	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ UNK Unknown ☐ Asked, but unknown	
9. Patient Ethnicity	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Asked, but unknown	

Indicate number of specimens: _____RED _____LAV _____GOLD _____LT. BLUE _____GREY _____GREEN _____PINK _____UA _____UR CULT. _____CULT. SWAB _____OTHER

◊ Reflex testing performed. Guidelines on form back. # Research-only test. Not reimbursable by Medicare * * Medicare Limited Coverage Test. See Medicare FOIA Medical Policies at www.cms.gov 2004