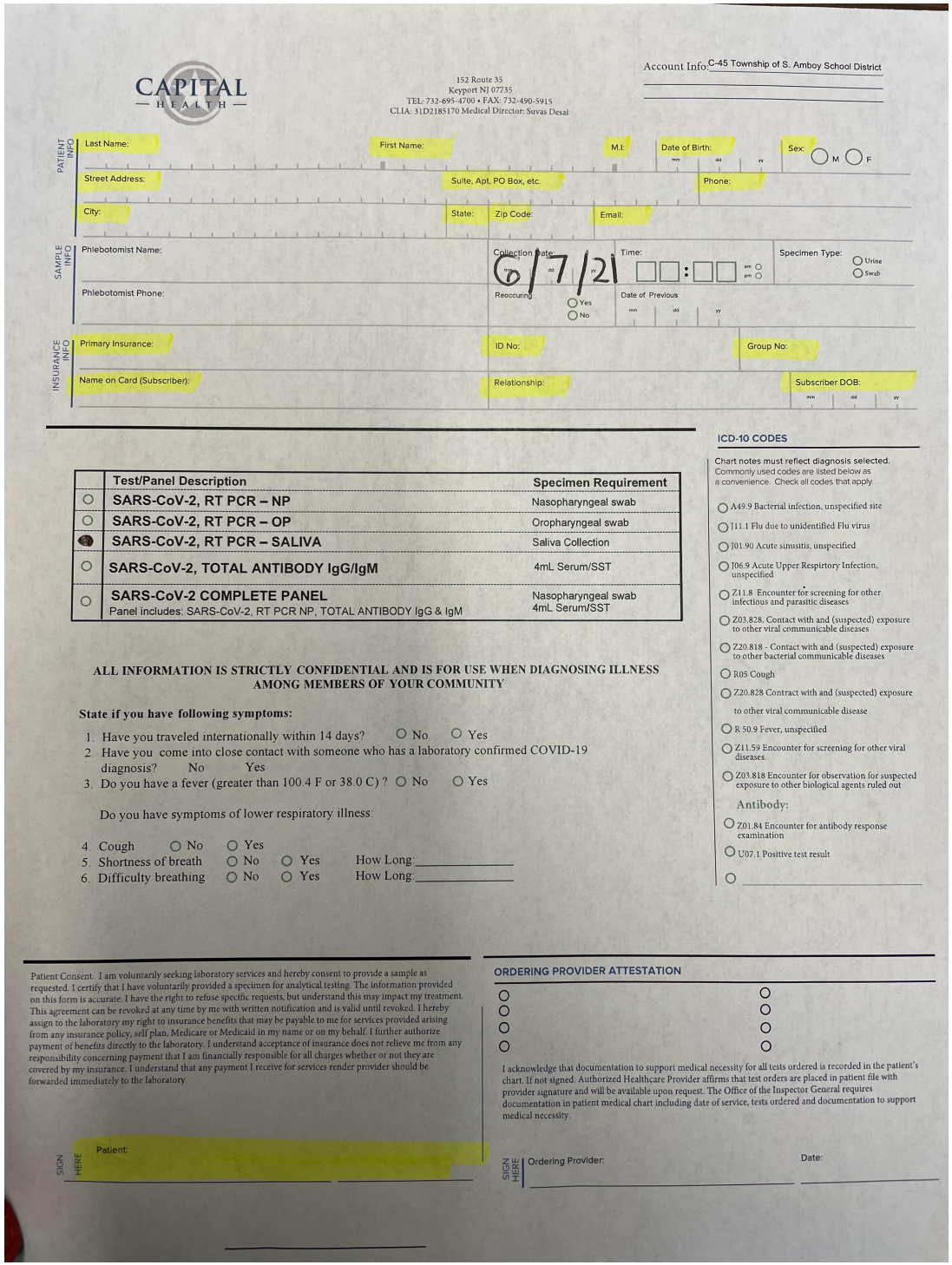

CAPITAL HEALTH

152 Route 35
Keyport NJ 07735
TEL: 732-695-4700 • FAX: 732-490-5915
CLIA: 31D2185170 Medical Director: Suvas Desai

Account Info: C-45 Township of S. Amboy School District

PATIENT INFO

Last Name: First Name: M.I: Date of Birth: mm dd yy Sex: M F

Street Address: Suite, Apt, PO Box, etc. Phone:

City: State: Zip Code: Email:

SAMPLE INFO

Phlebotomist Name: Collection Date: 6/7/21 Time: □□:□□ am pm Specimen Type: Urine Swab

Phlebotomist Phone: Reoccuring: Yes No Date of Previous: mm dd yy

INSURANCE INFO

Primary Insurance: ID No: Group No:

Name on Card (Subscriber): Relationship: Subscriber DOB: mm dd yy

	Test/Panel Description	Specimen Requirement
○	SARS-CoV-2, RT PCR – NP	Nasopharyngeal swab
○	SARS-CoV-2, RT PCR – OP	Oropharyngeal swab
●	SARS-CoV-2, RT PCR – SALIVA	Saliva Collection
○	SARS-CoV-2, TOTAL ANTIBODY IgG/IgM	4mL Serum/SST
○	SARS-CoV-2 COMPLETE PANEL Panel includes: SARS-CoV-2, RT PCR NP, TOTAL ANTIBODY IgG & IgM	Nasopharyngeal swab 4mL Serum/SST

ALL INFORMATION IS STRICTLY CONFIDENTIAL AND IS FOR USE WHEN DIAGNOSING ILLNESS AMONG MEMBERS OF YOUR COMMUNITY

State if you have following symptoms:

1. Have you traveled internationally within 14 days? ○ No ○ Yes
2. Have you come into close contact with someone who has a laboratory confirmed COVID-19 diagnosis? No Yes
3. Do you have a fever (greater than 100.4 F or 38.0 C) ? ○ No ○ Yes

Do you have symptoms of lower respiratory illness:

4. Cough ○ No ○ Yes
5. Shortness of breath ○ No ○ Yes How Long:_____
6. Difficulty breathing ○ No ○ Yes How Long:_____

ICD-10 CODES

Chart notes must reflect diagnosis selected. Commonly used codes are listed below as a convenience. Check all codes that apply:

- ○ A49.9 Bacterial infection, unspecified site
- ○ J11.1 Flu due to unidentified Flu virus
- ○ J01.90 Acute sinusitis, unspecified
- ○ J06.9 Acute Upper Respirtory Infection, unspecified
- ○ Z11.8 Encounter for screening for other infectious and parasitic diseases
- ○ Z03.828, Contact with and (suspected) exposure to other viral communicable diseases
- ○ Z20.818 - Contact with and (suspected) exposure to other bacterial communicable diseases
- ○ R05 Cough
- ○ Z20.828 Contract with and (suspected) exposure to other viral communicable disease
- ○ R 50.9 Fever, unspecified
- ○ Z11.59 Encounter for screening for other viral diseases.
- ○ Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out

Antibody:

- ○ Z01.84 Encounter for antibody response examination
- ○ U07.1 Positive test result
- ○ _____

Patient Consent. I am voluntarily seeking laboratory services and hereby consent to provide a sample as requested. I certify that I have voluntarily provided a specimen for analytical testing. The information provided on this form is accurate. I have the right to refuse specific requests, but understand this may impact my treatment. This agreement can be revoked at any time by me with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services render provider should be forwarded immediately to the laboratory.

SIGN HERE Patient: _____

ORDERING PROVIDER ATTESTATION

○ ○
○ ○
○ ○
○ ○

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

SIGN HERE Ordering Provider: _____ Date: _____