PATHOLOGY CONSULTANTS OF NEW MEXICO

FOCUSED ON PRECISION

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COVID-19 TEST FORM

PATIENT INFORMATION

Last Name	First Name	Middle Name	DOB

SSN	☐ Male ☐ Female	Mobile Phone Number

Address	City/State/Zip/County

Patient Signature

INSURANCE INFORMATION (please indicate if self pay)

Health Insurance Company Name	Member ID	Group Number

Policyholder Name	Policyholder DOB

CASE DETAILS

Procedure Performed at (please provide facility name)	Collection Date

Clinician	Copy to (please provide physician or facility name)

CARE STATUS - MUST CHECK APPLICABLE

☐ Patient is Hospitalized
☐ ICU ☐ Inpatient

☐ Patient is Pending Surgery, Z01.812

☐ Patient is Symptomatic
Onset Date: _____

☐ Patient is Asymptomatic

COLLECTION SOURCE

☐ Nasal Swab

PREPAID

☐ Prepaid Surveillance Z11.52

☐ Prepaid Travel Z11.52

ICD-10 CODING

☐ Z20.822, contact with and (suspected) exposure to COVID-19
☐ R07.0, sore throat
☐ R51.9, headache
☐ R52, body aches
☐ R05.9, cough
☐ R43.8, loss of taste and smell
☐ R06.02, shortness of breath
☐ R50.9, fever - unspecified
☐ Z11.52, encounter for screening for other viral diseases

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: _____