Danner Laboratory

Improving Lives With Cytology & Molecular Testing

COVID-19 Laboratory Order

MEDICAL PROVIDER INFORMATION

Physician Name		Facility Name
Phone number	Address	Date of Collection

PATIENT INFORMATION

Patient Name-Last, First, Middle Initial			Date of Birth	Age
Address- Number, Street, Apt #	City		State	ZIP Code
Primary Phone	Sex	Race	Ethnicity	

Billing Info- **Copy of Insurance Card Required**

☐Insurance ☐Patient ☐Client Bill ☐Medicare ☐Uninsured | Primary Insurance Company____________________ ID #____________ Group #____________

Occupation: ☐ Healthcare Worker ☐ Teacher ☐ EMT ☐ Other: ____________________

CLINICAL INFORMATION

Date of onset	Hospitalized? ☐ Yes ☐ No	Date of admission	Medical Record Number

Does the patient have the following signs and symptoms (check all that apply)?

☐ None	☐ Muscle aches	☐ Sore throat	☐ Subjective Fever	☐ Abdominal pain
☐ Cough	☐ Diarrhea	☐ Chills	☐ Runny nose	☐ Other, Specify:__________
☐ Shortness of breath	☐ Fever[1] (>100.4F or 38C)	☐ Vomiting or nausea	☐ Headache	☐ Unknown

Severe Acute Lower Respiratory Illness: (☐ pneumonia **OR** ☐ ARDS): Chest x-ray/CT results: ____________________

Pre-existing medical conditions (check all that apply):

☐ None ☐ Unknown ☐ Pregnancy ☐ Diabetes ☐ Hypertension ☐ Cardiovascular disease ☐ Chronic pulmonary disease

☐ Asthma ☐ Chronic renal disease ☐ Chronic liver disease ☐ Immunocompromised ☐ Neurologic disability

☐ Other:____________________

LABORATORY INFORMATION

Nasal pharyngeal swab:	Date of Collection: __________	Result: __________	Performing lab name: Danner Laboratory
Oropharyngeal swab:	Date of Collection: __________	Result: __________	Performing lab name: Danner Laboratory

Race:

☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐White
☐Other
☐Unknown

Ethnicity:

☐Hispanic or Latino
☐Not Hispanic or Latino

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