COVID-19 NPHL REQUISITION

PATIENT LAST NAME

FIRST NAME

DATE OF BIRTH AGE SEX

/ /

M / F

ADDRESS

APT

CITY STATE ZIP

COUNTY PHONE

EMAIL

PHYSICIAN'S NAME PHONE #

COLLECTION DATE COLLECTION TIME

/ /

AM / PM

ID / CHART NUMBER (NUMBER WILL APPEAR ON REPORT)

NATIONAL GUARD SITE LOCATION:

Clinical Diagnosis: ICD 10 Code:

Race __White __Black __Native American __Hispanic __Asian/Pacific Islander__Unknown __Other ___Non-Hispanic

Ethnicity __Hispanic __Non-Hispanic

Source: Nasopharyngeal Swab Sputum Serum Other:

__ COVID-19 Surveillance Testing - COVID-19 PCR Panel (CDC)

Do any of these apply

☐ 1. Hospitalized, suspected COVID-19

☐ 2. Healthcare worker

☐ 3. Public Safety/First Responder (EMS, law enforcement, firefighter)

☐ 4. Resident at group home (nursing home, homeless shelter, daycare)

☐ 5. Staff at group home (nursing home, homeless shelter, daycare)

☐ 6. Direct or close contact to a patient with COVID-19, within 14 days

☐ 7. Individuals > 65 years old, or patient with serious underlying conditions

☐ 8. Travel outside of Nebraska within 14 days

☐ 9. Other high risk setting: meat processing plant, large manufacturer, etc.

☐ 10. Other, please specify ____________________________________________

Worksite or Facility Name/Location ___________________________ / ___________________________

COVID-19 Requisition v2.2020
Onset Date of Symptoms: ____/____/_____

**Symptoms**

☐ Fever or chills
☐ Cough
☐ Shortness of breath, or trouble breathing
☐ Sore throat
☐ Runny nose
☐ Loss of taste

☐ Loss of smell
☐ Diarrhea
☐ Fatigue
☐ Congestion
☐ Other, please specify

**Risk Categorization**

High risk = if hospitalized OR symptomatic OR healthcare worker OR resident at group home OR staff at group home.

Low risk = does not meet high risk definition

*Based on Risk Categorization, this specimen is classified as:*  ☐ High risk  ☐ Low risk