Order form for COVID testing to be provided by Valley View Hospital lab. (970-384-7590)

Fax Completed order to: 970-945-2495

Or place with specimen in biohazard bag

****

Date Ordered: _____

Patient First Name: _____

Patient Last Name: _____

Patient Date of Birth: _____

Patient Phone #: _____

Specimen collected by: _____

Date Collected: _____ Time Collected:_____

Diagnosis code: Select appropriate

☐ Z03.818 Possible exposure to COVID-19, ruled out after evaluation

☐ Z20.828 Actual (Suspected) exposure to COVID-19 to someone who is confirmed

☐ Z11.59 Screening for Asymptomatic individual, no known exposure to Covid-19

☐ RO5 Cough

☐ R06.2 Shortness of Breath

☐ R50.9 Fever, unspecified

☐ Other Symptoms: _____

Test to be done: Please circle

COVID PCR **Source of specimen:** NP Swab Nasal Oral

COVID IgG Antibody *(Red top tube)*

Physician Signature _____ Date _____ Time _____

Print Provider Name: _____

Phone # of Provider for Critical results:_____

Fax # to send results to: _____

* P O . O U T P T *

Valley View