Skilled Nursing Facilities Testing Initiative Updates

25 June 2020
COVID-19 Specimen Acceptance

• Specimen Identification
  • Patient first name, last name, and DOB

• Specimen Collection
  • Date and time of collection

• Specimen Transport
  • Must meet temperature requirements for the collection device (Exact supplies 2-8C)

Specimens that do not meet these criteria will be rejected
### Provider & Order Information

<table>
<thead>
<tr>
<th>PROVIDER INFORMATION</th>
<th>ORDER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Organization Name:</td>
<td></td>
</tr>
<tr>
<td>Provider Name:</td>
<td></td>
</tr>
<tr>
<td>NPI #:</td>
<td></td>
</tr>
<tr>
<td>Location Address:</td>
<td></td>
</tr>
<tr>
<td>City, State, Zip:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td></td>
</tr>
<tr>
<td>Secure Fax Number*:</td>
<td>To receive results for this order, please provide secure FAX number only</td>
</tr>
</tbody>
</table>

### Diagnostic Code(s):
- 220.828: Exposure to a confirmed/suspected case
- Z11.98: Screening for asymptomatic case

### Signs & Symptoms:
- RO: Cough
- RS0: Fever
- Other: |

### Certification
- I am a licensed healthcare provider authorized to order this test. This test is medically necessary and the patient is eligible. I will maintain the privacy of test results and related information as required by HIPAA.

### Ordering Provider Signature:

### Date of Order:

### SPECIMEN TYPE
- Specimen should be collected in viral or universal transport media, Amies, or RNAse free Normal saline.

- Nasopharyngeal (NP) Swab
- Throat (OP) Swab
- Mid-turbinate Swab
- Nasal Swab
- Other:

### Collection Date (mm/dd/yyyy):

### Collection Time:

### AM  PM

### Patient Demographics

### ALL FIELDS REQUIRED

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID/MRN:</td>
<td></td>
</tr>
<tr>
<td>DOB (mm/dd/yyyy):</td>
<td></td>
</tr>
<tr>
<td>First Name:</td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td>Male</td>
</tr>
<tr>
<td>Last Name:</td>
<td></td>
</tr>
<tr>
<td>Phone Number:</td>
<td>Home</td>
</tr>
<tr>
<td>Patient Address:</td>
<td></td>
</tr>
</tbody>
</table>

### City, State, Zip:

### PATIENT ETHNICITY AND RACE

- Is your patient of Hispanic or Latino origin or descent? Yes | No

- Please mark one or more to indicate your patient’s race:
  - White
  - Black or African-American
  - Asian
  - Native Hawaiian or other Pacific Islander
  - American Indian or Alaska Native

### Sample Label Information:

- For Lab Use Only

- Sample Collected: __/__/__
- Sample Received: __/__/__
Questions on Results?

Call 844-570-9730 for additional support