SPECTRUM HEALTH
Lakeland

Laboratory Service Order Sheet – COVID-19 ONLY

Patient Information:			**PRIORITY STATUS**
Patient Name	DOB	Gender	□ STAT (S) Results will be telephoned □ FAX: (F) _____ □ Call: (W) Business Hours Only □ Call: © 24 Hours a day
Ordering Physician			
Referring /Copy to Physician			
Diagnosis / ICD 10 Codes			
Referring Office/Collection Site			

Ordering Information	
Order Date:	Diagnosis Code(s):
Date of Collection **(REQUIRED)**:	Collection Time **(REQUIRED)**:
Billing Information:	
Physician Signature:	**Date:**

Test Requested	
COVID-19 PCR □	**Specimen Source:** □ Nasopharyngeal □ Nares

Transport/Storage: Refrigerated
Ensure specimen container cap is secured.

*****REQUIRED INFORMATION (PLEASE COMPLETE)*****

Symptomatic for Covid-19 as defined by CDC? □ Yes □ No

If symptomatic, date of symptom onset _____

First Covid-19 Test? □ Yes □ No □ Unknown

Employed in healthcare setting? □ Yes □ No □ Unknown

Hospitalized with confirmed or suspected COVID-19? □ Yes □ No □ Unknown

Resident in congregate care/living setting? □ Yes □ No □ Unknown

Pregnant? □ Yes □ No □ Unknown