National Jewish Health
Breathing Science is Life.

# Physician Referral Form for COVID-19 Diagnostic Testing

**We cannot test your patient without this provider order and appointment.** Please fax the completed referral form to 303.270.2153. If possible, **fax a copy of the patient's insurance card or face sheet and photo identification** to 303.270.2153**.** Most physicians and patients will receive results within 24 hours of sample collection. Patients will be contacted for registration and scheduling. Patients MUST bring their photo identification and insurance (if available) and will sign consent upon arrival.

**Note: Antibody testing (IgG and IgM) is generally not appropriate for acutely ill patients. Patients referred for antibody testing who have had new or worsening fever, cough, or shortness of breath within the last two weeks may be offered only the molecular diagnostic (swab) test and not the antibody test.**

## Provider Information:

*Required

*Provider First Name: *Provider Last Name:

*Provider NPI: *Colorado Medical License Number:

Name of Requesting Office or Facility:

*Provider Address:

*Provider Phone Number: *Provider Fax Number:

## Patient Information:

*Patient First Name: *Patient Last Name:

*Patient Gender: ☐ Male ☐ Female ☐ Transgender

*Patient Date of Birth: *Patient Phone Number:

*If child, parent's/guardian's name:

*Patient Address:

## Insurance Information:

*Insurance Name:

*Member ID/Policy Number: Group Number:

*Insurance Referral/Authorization Number:

***Patient Symptoms/History** (check all that apply)

Comments

- ☐ Fever
- ☐ New or worsening cough
- ☐ New or worsening shortness of breath
- ☐ Close contact of known COVID-19 case
- ☐ Healthcare worker or first responder
- ☐ None of the above

*COVID-19 Diagnostic Testing Orders:

- ☐ COVID-19 PCR (SARS-CoV2 rRT-PCR)
- ☐ COVID-19 IgG
- ☐ COVID-19 IgM
- ☐ Respiratory Viral Panel

## *Provider Acknowledgement/Signature

By signing below, you attest that: You are a physician or advanced practice provider with a valid and active license in the state of Colorado. This patient does not require hospitalization. Based on this patient's signs/symptoms and exposure history, you believe COVID-19 diagnostic testing is clinically indicated.

*Signature: *Date: