COLORADO
Laboratory Services Division
Department of Public Health & Environment

8100 Lowry Boulevard
Denver, CO 80230-6928
Molecular: (303)692-3286
Serology: (303)692-3485
Lab COVID19 info: (303) 692-3090

For Laboratory Use Only

Company Information

Customer: Clinica Family Health - Lafayette
Company : Clinica Family Health - Lafayette
Address: 1735 South Public Road
Lafayette CO 80026
Report to: Jeff Raikes
Phone: 303-412-8180
Fax: 720-565-4133

☐ *Check box if this contact information is new or updated*

Patient Information

Patient ID:* ______
First Name:* ______
Last Name:* ______
Middle Name: ______
Date of Birth:* ______
Sex at birth:* ☐ Male ☐ Female
Patient Race:* ______
Hispanic/Latino* ☐ Yes ☐ No
Patient Phone:* ______ ☐ Mobile
Patient Email: ______

Sample Information

Sample ID* ______
Collect Date:* ______
Collected By: ______

Patient Address*
______
______
______

It is the responsibility of the customer to update the CDPHE laboratory if their contact information changes. Reports are sent to the contacts on file.
Fields Marked with and Asterisk(*) are REQUIRED and must be complete for testing to be performed
All sample collection tubes MUST have a matching, legible First Name, Last Name, and Date of Birth or Patient ID

Check the Sample Matrix

__Anterior Nares __Bronchial wash __Bronchoalveolar lavage __Buccal swab __E-swab __Lung tissue __NP and OP Swab in SINGLE TUBE __Nares __Nasal aspirate __Nasal swab __Nasal wash __Nasopharyngeal (NP) swab __Nasopharyngeal aspirate __Oropharyngeal swab __Saline Water __Serum __Sputum __Throat swab __Tracheal aspirate

Novel Coronavirus Community Testing
☐ Novel Coronavirus Testing

Epidemiologic Questions

Fever and / or Respiratory Symptoms?
☐ Yes ☐ No
Symptom Onset Date:______
Check all symptoms that apply:
☐ Fever over 100.4 F ☐ Runny Nose ☐ Nausea or Vomitting
☐ Felt Feverish ☐ Sore throat ☐ Shortness of Breath
☐ Chills ☐ Cough ☐ Abdominal Pain
☐ Muscle Aches ☐ Fatigue ☐ Loss of Taste or Smell
☐ Head Ache ☐ Diarrhea ☐ Increased Need for Oxygen
☐ Other:______
Hospitalized?
☐ Yes ☐ No
Lives in a Residential Facility?
☐ Yes ☐ No
☐ Nursing Home ☐ School/College Dorm
☐ Assisted Living ☐ Correctional Facility
☐ Independent Senior Living ☐ Homeless Shelter
☐ Other:______

☐ Patient consents to having results reported directly to them
Primary Care Provider Name:______
Primary Care Provider Phone:______
Primary Care Provider Address:______
Employer Name:______
Employer Address:______
What kind of work do you do:______
What kind of business do you work in?
______
Work Setting? Check all that apply:
☐ Healthcare- direct Patient Care ☐ Grocery Store ☐ Military
☐ Healthcare- no direct Patient ☐ Food Service ☐ Emergency Services
☐ Group Home ☐ Food Manufacturing/ Meat ☐ Corrections
☐ Childcare ☐ Construction ☐ Manufacturing - not food
☐ School- student ☐ Transportation ☐ Retail - not food
☐ School - teacher ☐ Agriculture ☐ Hospitality

Chain of Custody

Relinquished By: ______ Date/Time: ______ Relinquished By: ______ Date/Time: ______
Recieved By: ______ Date/Time: ______ Received By: ______ Date/Time: ______

VITAL SIGNS: Pulse ox________HR:________Temp:________

CDPHE Testing Criteria

Tier 1: Health care worker with symptoms
Tier 2:

- Patients in long-term care facilities or other residential settings such as homeless sheters or correctional facilities with symptoms
- Patients over age 65 with symptoms
- (HIGH RISK) Patients with 1 or more symptoms and underlying symptoms/deterioration risk:
  - Chronic lung disease
  - Diabetes mellitus
  - Pregnancy
  - Immunocompromised
  - Heart disease
  - Chronic kidney disease
  - Chronic liver disease
- Neonates (0 to 30 days of age) of a COVID19+ mother
- Low-risk individual with symptoms living with high risk individuals
- Symptomatic individual needing high risk dental procedure
- First responders with symptoms
- Critical infrastructure workers with symptoms
- People with symptoms who work with vulnerable populations

Tier 3: Other individual with symptoms who have a SYMPTOM SCORE greater than or equal to 2 (Note: for chronic symptoms (i.e. cough or fatigue) consider positive if worsened over the last 2 weeks)

Symptom Score_________

○Fever 2	○Rhinorrhea 1	○Dysgeusia/ageusia (chg/loss of taste) 1
○Cough 2	○Pharyngitis 1	○Dysosmia/asosmia (chg/loss of smell) 1
○Shortness of breath 2	○Abdominal Pain 1	○Myalgia 1
○Household contact 1	○Diarrhea 1	○Severe Fatigue 1

ICD10 Diagnosis Code: Cough R05 Fever R50.9 SOB R06.02 Suspected COVID Z20.828

Preferred Pharmacy:____________________________

Insurance Provider: ______________________________ Policy Number: _____________________________

In order for us to provide you with medical, dental and behavioral healthcare, we are required to obtain consent from you. By signing and providing consent, you as a patient still have the right to choose what services and care you receive.

Refusing to sign this form prevents us from seeing you as a patient.

By signing, I hereby give permission for Clinica Family Health to provide healthcare services to all persons listed on this form. This includes permission to bill my insurance company or others who are responsible to pay for my healthcare services and for the release of any medical records needed to obtain payment for these services.

Today's Date: ____________

Patient or Parent/Guardian (If under 18 years of age):

Clinica Family Health Employee receiving verbal consent: ______________________________________

During check-in at each office visit, we will verify your private medical insurance to determine it is active. Not all services are a covered benefit in all contracts. You are responsible for payment for any fees not paid by your insurance carrier. There is a 20% prompt pay discount if you pay within 30 days of the invoice mail date.