Oneida Health

Name:____DOB:_______________________

Phone# ______________________________ Alternate Phone # ______________________________

Street Address:____

City: _________________State:______________Zip Code:__________ NYS County of Residence:____________

Criteria for Testing (MUST CHECK AT LEAST ONE TO QUALIFY FOR TEST):

☐ Patient is asymptomatic and testing is required due to scheduled elective procedure.
Indicate Reason for Procedure (Diagnosis):______________________________

DATE of Procedure:________________________________

☐ Proximate contact (same room or gathering) with a person that is known positive for COVID- 19 (Z20.822)

☐ Individual is employed as a health care worker, first responder, or other essential worker who directly interacts with the public while working

☐ Traveled to a region with high COVID-19 prevalence

☐ Is under mandatory or precautionary quarantine & has symptoms (cough, fever, SOB) of COVID-19

☐ Symptomatic (cough, fever, SOB) for COVID-19. **Please indicate**

☐Headache ☐Cough ☐Fever ☐SOB ☐Sinus Congestion ☐ OTHER __________

☐ Worker Returning per the Governor’s Phasing Program

☐ Symptomatic Student requiring testing in order to return to school.

☐ Other cases where the facts and circumstances warrant as determined by the treatingclinician

I understand that this form must be completed in its entirety in order for testing to occur. I certify that the information above is true and correct to the best of my understanding.

☐ I authorize this patient to be tested for Influenza.

☐ I authorize this patient to be tested for COVID-19.

☐ I authorize this patient to be tested for Strep

Ordering Provider Name (**PRINT**)____

____ ________________
Ordering Provider Signature Date / Time

*** Fax Form to: 315-361-2912***

EDM 01891 Covid19 Requisition 03/24/20

Rev. 03/26/20, 04/22/20, 04/29/20, 05/07/*20, 05/19/20, 09/24/20, 10/29/20, 11/19/20, 12/17/20. 01/06/21