OLOLCH HCS COMMUNITY COVID-19 ORDER AND CASE FORM

Patient Information

Legal Name	Date of Birth	Age	Sex:	Race:

Patient Phone	Emergency Contact Name	Emergency Contact Phone Number

Patient/Parent Email Address	Name of School/Office Location and Grade Level:

Patient Address (Address, City, State, Zip)	Parish of Residence

Primary Care Physician Name	Insurance Company Name

Insurance Group #	Insurance Member ID	Relationship to Insured ☐ Self ☐ Dependent ☐Spouse

Symptoms: **Onset Date: _____**

- ☐ Fever, Temp_____
- ☐ Chills
- ☐ Muscle Aches
- ☐ Sore Throat
- ☐ New or Worsening Cough
- ☐ Shortness of Breath
- ☐ Headache
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Loss of taste/smell
- ☐ NA

Date of exposure/close contact with positive individual: _____

Does the patient have any co-morbid conditions?

- ☐ COPD
- ☐ Cardiovascular Disease
- ☐ Diabetes
- ☐ Obesity
- ☐ CKD
- ☐ Asthma
- ☐ Other _____

To be Completed by School Health Staff

Date:

Testing Order: COVID-19

Diagnosis	ICD-10
☐ **Fever, Unspecified**	R50.9
☐ **Cough**	R05
☐ **Shortness of Breath**	R06.02
☐ **Suspected COVID-19**	R68.89
☐ **Screening for COVID-19**	Z11.59
☐ **Encounter for laboratory testing for COVID-19 virus**	Z20.828
☐ **Other:**	

Results Communicated/Follow Up Provided

Was COVID-19 Testing Positive? ☐ **Yes** ☐ **No**	Date patient/parent notified of results: _____ Staff who contacted patient/parent: _____

Ordering Provider:

✓ Standing Order Protocol signed by Dr. Sylvia Sutton, HCS Medical Director