ASPEN VALLEY HOSPITAL

Patient Sticker

Referral Form for COVID-19 PCR Test in the Respiratory Evaluation Clinic

Patient Name: _____ DOB: _____

Patient phone number: _____

Referring Provider: _____ Referring Provider Phone #:_____

Patient Insurance: _____

Any of the following symptoms:

- ✓ Fever of 100.4 or greater
- ✓ Cough
- ✓ Shortness of breath
- ✓ Loss of taste/smell

OR two of the following symptoms:

- ✓ Fatigue
- ✓ Body aches
- ✓ Headache
- ✓ Sore throat
- ✓ Chills
- ✓ Diarrhea
- ✓ Nausea/Vomiting
- ✓ Loss of Appetite

Test Requested: □ COVID-19 PCR test in Respiratory Evaluation Clinic

ICD-10CM Diagnosis:

☐ Actual Exposure to COVID-19 virus – Z20.828

☐ No known exposure to virus – Z11.59

☐ Possible Exposure to virus – Z03.818

☐ Confirmed virus infection – U07.1

☐ History of infection – Z86.19

☐ Sequelae of infection – B94.8

Provider Signature (Physician, NP, PA) :_____ Date/Time: _____

Fax to AVH scheduling 970-544-1589 M-F and 970-544-1590 on the weekends.

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