

Dental Office Order form for COVID testing to be provided by Valley View Hospital lab. (970-384-7590)

Fax Completed order to: 970-945-2495

Or place with specimen in biohazard bag

Date Ordered: _____

Patient First Name: _____

Patient Last Name: _____

Patient Date of Birth: _____

Patient Phone #: _____

Specimen collected by: _____

Date Collected: _____ Time Collected: _____

Diagnosis code: Select appropriate

- Z03.818 Possible exposure to COVID-19, ruled out after evaluation
- Z20.828 Actual (Suspected) exposure to COVID-19 to someone who is confirmed
- Z11.59 Screening for Asymptomatic individual, no known exposure to Covid-19
- RO5 Cough
- R06.2 Shortness of Breath
- R50.9 Fever, unspecified
- Other Symptoms: _____

Test to be done: Please circle

COVID PCR	Source of specimen:	NP Swab	Nasal	Oral
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Dentist Signature _____ Date _____ Time _____

Print Provider Name: _____

Phone # of Provider for Critical results: _____

Fax # to send results to: _____

