



Summit Clinical  
Laboratories

2850 HERITAGE DR  
DELAFIELD, WI 53018

# Covid-19 PCR Test

## LAKE COUNTRY - DELAFIELD

### Collection Site

ACCEPTING Governmental Plans (Medicaid, Medicare, Tricare)-Private Insurance (Group Health Plans, Individual Health Plans)-Uninsured Patients.  
Some Non-traditional plans may have Exceptions as well as testing for Travel.

1. PATIENT INFORMATION		
LAST NAME	FIRST NAME	MI
ADDRESS		
CITY	STATE	ZIP
PHONE	DOB (MM/DD/YYYY)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ANCESTRY	<input type="checkbox"/> CAUCASIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN	<input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> HISPANIC/LATINO
	<input type="checkbox"/> ASIAN <input type="checkbox"/> HAWAIIAN/P. ISLANDER <input type="checkbox"/> OTHER	
EMAIL		

2. REASON FOR TESTING (CHECK ALL THAT APPLY)	
Have you or anyone you are in close contact with been in contact with anyone who has tested positive Covid-19 in the last 30 days?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you traveled outside the state in the last 30 days? If so Where? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SYMPTOMS OF COVID-19	<input type="checkbox"/> ASYMPTOMATIC
<input type="checkbox"/> Fever R50.9	<input type="checkbox"/> Muscle aches (myalgia) M79.10
<input type="checkbox"/> Cough R05	<input type="checkbox"/> Fatigue R53.1
<input type="checkbox"/> Sore Throat J02.9	<input type="checkbox"/> Runny Nose (rhinorrhea) R09.82
<input type="checkbox"/> Shortness of Breath(dyspnea) R06.00	<input type="checkbox"/> Vomiting R11.10
<input type="checkbox"/> Nausea R11.0	<input type="checkbox"/> Diarrhea (more than 3 loose stools) R19.7
<input type="checkbox"/> Abdominal pain R10.9	<input type="checkbox"/> Loss of Smell? R43.8
<input type="checkbox"/> Chills R68.83	<input type="checkbox"/> Loss of Taste? R43.9
<input type="checkbox"/> Headache R51	<input type="checkbox"/> Other _____
Why are you getting tested today? _____	

3. SPECIMEN COLLETION			
SPECIMEN TYPE	COLLECTION	TIME OF	AM <input type="checkbox"/>
<input checked="" type="checkbox"/> Nasal Swab	DATE (MM/DD/YY)	COLLECTION (HH:MM)	PM <input type="checkbox"/>

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