

Michigan Interim COVID-19 Person Under Investigation (PUI) Case Report Form

Patient Information:

First name: _____ Last name: _____

Date of birth: ____/____/____ Age: ____ Sex: ☐ Female ☐ Male

Patient residence street address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Patient phone number(s): _____ / _____

Patient hospital ID (Medical Record) number: _____

Submitting Facility Information:

Reporting healthcare facility: _____

Reporting healthcare facility contact name and title: _____

Healthcare facility contact phone number: _____

Reason for Testing:

1.) Ensures optimal care options for all hospitalized patients, lessen the risk of healthcare-associated infections, and maintain the integrity of the U.S. healthcare system:

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Hospitalized Patients

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Healthcare Facility workers with symptoms

2.) Ensures those at highest risk of complication of infection are rapidly identified and appropriately triaged:

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Patients in long-term care facilities or any other congregate living arrangement (i.e., dormitories, jails/prisons, camps, group homes, institutional settings, skilled nursing facilities, etc.) with symptoms

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Patients over 65 years of age with symptoms

☐

Patients with underlying conditions with symptoms

☐

First responders with symptoms

3.) Ensures the health of essential workers in Michigan Communities:

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Critical Infrastructure workers with symptoms

- Critical Infrastructure is defined in Executive Order 2020-21, in section 8 and 9 of the order (EO 2020-21). Critical infrastructure workers can be characterized as those individuals who, under Executive Order 2020-21, should be considered essential and should continue to report to their place of work in order to sustain necessary operations. This does not include those who are permitted or required to work from remote locations, such as home.

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Any individual with mild presentation of symptoms consistent with COVID-19

- This criterion should only be considered if adequate testing capacity exists in the provider's area, after first prioritizing individuals who meet any of the above criteria.

Specimen Being Submitted to:

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MDHHS BOL- PUI (nCoV) ID#: MI-_____ (Required). Assigned by case entry into MDSS by healthcare facility staff or via the Mi-CLERN provider hotline at: (888) 277-9894.

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Clinical or Commercial lab. PUI (nCoV) ID is not required.

		General Health		BILL TO: <input type="checkbox"/> My Account <input type="checkbox"/> Insurance Provided <input type="checkbox"/> Lab Card/Select <input type="checkbox"/> Patient		PRINT PATIENT NAME (LAST, FIRST, MIDDLE)	
ACCOUNT #		NAME		REGISTRATION # (IF APPLICABLE)		DATE OF BIRTH	
ADDRESS		CITY, STATE, ZIP		PATIENT SOCIAL SECURITY #		OFFICE / PATIENT ID #	
TELEPHONE #				ROOM #		LAB REFERENCE #	
				PATIENT PHONE #			
				PRINT NAME OF INSURED/RESPONSIBLE PARTY (LAST, FIRST, MIDDLE) - IF OTHER THAN PATIENT			
				PATIENT STREET ADDRESS (OR INSURED/RESPONSIBLE PARTY) APT. #		KEY #	
DATE COLLECTED		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM		TOTAL VOL./HRS. <input type="checkbox"/> Fasting <input type="checkbox"/> Non Fasting		CITY	
NPI/UPIN ORDERING/SUPERVISING PHYSICIAN AND/OR PAYORS (MUST BE INDICATED)						STATE ZIP	
						RELATIONSHIP TO INSURED: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
						PRIMARY INSURANCE CO. NAME	
						MEMBER / INSURED ID NO. #	
						GROUP #	
						INSURANCE ADDRESS	
						CITY	
						STATE ZIP	
<input type="checkbox"/> ADD'L PHYS.: Dr. NPI/UPIN							
NON-PHYSICIAN PROVIDER: NAME		ID.#					
<input type="checkbox"/> Fax Results to: ()							
Send Client # OR NAME:							
Duplicate ADDRESS:							
Report to: CITY:		STATE		ZIP			
PANEL COMPONENTS ON BACK		ORGAN / DISEASE PANELS		HEMATOLOGY		OTHER TESTS	
34392 <input type="checkbox"/> Electrolyte Panel S		4420 <input type="checkbox"/> C-Reactive Protein (CRP) S		571 <input type="checkbox"/> Iron S		6448 <input type="checkbox"/> UA, Dipstick Only U	
10256 <input type="checkbox"/> Hepatic Function Panel S		29493 <input type="checkbox"/> CA 27.29 S		593 <input type="checkbox"/> LDH S		7909 <input type="checkbox"/> UA, Dipstick w/Reflex Microscopic U	
10165 <input type="checkbox"/> Basic Metabolic Panel S		29256 <input type="checkbox"/> CA 125 S		599 <input type="checkbox"/> Lead, Blood TN		5463 <input type="checkbox"/> UA, Complete (Dipstick & Microscopic) U	
10231 <input type="checkbox"/> Comp Metabolic Panel S		303 <input type="checkbox"/> Calcium S		615 <input type="checkbox"/> LH S		3020 <input type="checkbox"/> UA, Complete, w/Reflex Culture U	
7600 <input type="checkbox"/> Lipid Panel (Fasting) S		11173 <input type="checkbox"/> CCP Ab IgG S		606 <input type="checkbox"/> Lipase S		294 <input type="checkbox"/> Urea Nitrogen (BUN) S	
14852 <input type="checkbox"/> Lipid Panel w/Reflex D-LDL S		978 <input type="checkbox"/> CEA S		6646 <input type="checkbox"/> Lyme Disease Ab w/Reflex to Biot (IgG, IgM) S		905 <input type="checkbox"/> Uric Acid S	
20210 <input type="checkbox"/> Obstetric Panel w/Reflex Y,L,S		334 <input type="checkbox"/> Cholesterol, Total S		622 <input type="checkbox"/> Magnesium S		916 <input type="checkbox"/> Valproic Acid SR	
10306 <input type="checkbox"/> Hepatitis Panel, Acute w/Reflex S		374 <input type="checkbox"/> CK, Total S		6517 <input type="checkbox"/> Microalbumin, Random Urine w/Creat S		4439 <input type="checkbox"/> Varicella-Zoster Virus Ab (IgG) S	
10314 <input type="checkbox"/> Renal Functional Panel S		375 <input type="checkbox"/> Creatinine S		Fecal Globin, Feces - FIT, InSure [®] 1		7065 <input type="checkbox"/> Vitamin B12/Folic Acid S	
		402 <input type="checkbox"/> DHEA Sulfate, Immunoassay S		11290 <input type="checkbox"/> Diagnostic F 11293 <input type="checkbox"/> Medicare Screen		927 <input type="checkbox"/> Vitamin B12 S	
		8293 <input type="checkbox"/> LDL Cholesterol, Direct S		718 <input type="checkbox"/> Phosphorus S		17306 <input type="checkbox"/> Vitamin D, 25-Hydroxy, Total, Immunoassay S	
		4021 <input type="checkbox"/> Estradiol S		733 <input type="checkbox"/> Potassium S		91935 <input type="checkbox"/> Vitamin D (QuestAssureD [™] for Infants) SR	
		457 <input type="checkbox"/> Ferritin S		745 <input type="checkbox"/> Progesterone S		25-Hydroxyvitamin D, LC/MS/MS (<3 yrs)	
		466 <input type="checkbox"/> Folic Acid S		746 <input type="checkbox"/> Prolactin S		MICROBIOLOGY	
		470 <input type="checkbox"/> FSH S		5363 <input type="checkbox"/> PSA, Total S		Source (Required)	
		482 <input type="checkbox"/> GGT S		793 <input type="checkbox"/> Reticulocyte Count, Automated L		4550 <input type="checkbox"/> Culture, Aerobic Bacteria*	
		8477 <input type="checkbox"/> Glucose, Gestational Screen (50g), 135 cutoff GY		4418 <input type="checkbox"/> Rheumatoid Factor S		4446 <input type="checkbox"/> Culture, Aerobic & Anaerobic*	
		19833 <input type="checkbox"/> Glucose, Gestational Screen (50g), 140 cutoff GY		799 <input type="checkbox"/> RPR (Monitoring) w/Reflex Titer S		4485 <input type="checkbox"/> Culture, Group A Strep*	
		484 <input type="checkbox"/> Glucose, Plasma GY		36126 <input type="checkbox"/> RPR (DX) w/Reflex Confirm S		5617 <input type="checkbox"/> Culture, Group B Strep*	
		483 <input type="checkbox"/> Glucose, Serum S		802 <input type="checkbox"/> Rubella IgG S		4558 <input type="checkbox"/> Culture, Genital*	
		8435 <input type="checkbox"/> hCG, Serum, Quant S		809 <input type="checkbox"/> Sed Rate by Mod West L		394 <input type="checkbox"/> Culture, Throat*	
		8396 <input type="checkbox"/> hCG, Serum, Qual S		15983 <input type="checkbox"/> Testosterone, Total, LC/MS/MS SR		395 <input type="checkbox"/> Culture, Urine, Routine* (Inc. Indwelling Cath)	
		496 <input type="checkbox"/> Hemoglobin A1c L		873 <input type="checkbox"/> Testosterone, Total, Male SR		Amplified Specimen Type (Aptima)	
		16802 <input type="checkbox"/> Hemoglobin A1c w/eAG L		5081 <input type="checkbox"/> Thyroid Peroxidase Antibodies (TPO) S		<input type="checkbox"/> Endocervical <input type="checkbox"/> Urthral <input type="checkbox"/> Urine	
		499 <input type="checkbox"/> Hep B Surface Ab Qual S		896 <input type="checkbox"/> Triglycerides S		11363 <input type="checkbox"/> Chlamydia & N. gonorrhoeae RNA, TMA	
		498 <input type="checkbox"/> Hep B Surface Ag w/Reflex Confirm S		899 <input type="checkbox"/> TSH S		Stool Pathogens (Salm/Shig/Campy)	
		8472 <input type="checkbox"/> Hep C Antibody w/Reflex to Quant S		36127 <input type="checkbox"/> TSH w/Reflex T4, Free S		10108 <input type="checkbox"/> Culture, Stool, Shiga toxins w/Reflex*	
		91431 <input type="checkbox"/> HIV-1/2 AG/AB, 4th w/Reflex S		34429 <input type="checkbox"/> T3, Free S		34838 <input type="checkbox"/> H. pylori Ag, EIA Stool	
		31789 <input type="checkbox"/> Homocysteine S		859 <input type="checkbox"/> T3, Total S		14839 <input type="checkbox"/> H. pylori Urea Breath Test HB	
		10124 <input type="checkbox"/> hs CRP S		861 <input type="checkbox"/> T3 Uptake S		681 <input type="checkbox"/> O & P w/Permanent Stain	
		561 <input type="checkbox"/> Insulin S		867 <input type="checkbox"/> T4 (Thyroxine), Total S			
		549 <input type="checkbox"/> Immunofixation (IFE) S		866 <input type="checkbox"/> T4 (Thyroxine), Free S			
		573 <input type="checkbox"/> Iron, TIBC, % Sat S					
ADDITIONAL TESTS: (INCLUDE COMPLETE TEST NAME AND ORDER CODE)							
COMMENTS, CLINICAL INFORMATION:				TOTAL TESTS ORDERED			
Physician Signature (Required for PA, NY, NJ & WV)							