COVID 19 TEST REQUISITION

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ICD-10 Diagnostic Code(s): ☐ **Z11.59 - Screening for COVID**

Hospital/ Laboratory or Facility ______________________ Account #: __________

Point of Contact: ______________________

Address: ______________________

Phone: ______________________ Fax: ______________________

Ordering Physician: ______________________

Address: ______________________

Phone: ______________________ Fax: ______________________

Physician Signature: ______________________

Bill to: ☐ Hospital ☐ Client ☐ Patient ☐ Insurance ☐ Medicare/Medicaid ☐ Other______________________

Patient Information:

Patient's Name: ______________________ Gender ☐ M ☐ F Date of Birth: ______________ Pregnancy Status: ☐ Yes ☐ No

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Patient's Phone #: ______________________ Patient Email (necessary for individual report portal access): ______________________

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan ☐ Asian Pacific Islander ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic ☐ Unknown ☐ Decline

Patient Signature: ______________________ Today's Date: __________

Insurance Information:

Insured/Responsible Party: ______________________ Social Security #: ______________ Gender M F Date of Birth: __________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Phone: ______________ Member ID #: ______________ Policy #: ______________ Group # : ______________

Insurance Co. Name: ______________ Insurance Address : ______________ City: ______________ State: ________ Zip: ________

Relationship to Insured/Responsible Party: ☐ Self ☐ Spouse ☐ Dependent

COVID 19 TESTING

☐ SARS-CoV-2, NAAT RT- PCR Assay Source: ☐ Nasal ☐ Nasopharyngeal ☐ Oropharyngeal

Collection Time: Collection Date:

Is the patient experiencing any of the following symptoms:

☐ Fever or chills ☐ Cough ☐ Sore throat ☐ Shortness of breath ☐ Headache ☐ Nausea or vomiting ☐ Diarrhea ☐ Muscle or body aches
☐ Fatigue ☐ Congestion or runny nose ☐ Loss of smell and taste

Clinical History: ______________________

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****Please include relevant clinical history, lab results and insurance information with requisition****

Name:______________	Name:______________	Name:______________	Name:______________
Specimen:______________	Specimen:______________	Specimen:______________	Specimen:______________
DOB_____/_______/_________	DOB_____/_______/_________	DOB_____/_______/_________	DOB_____/_______/_________

LAB COPY