Laboratory Requisition

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PATIENT INFORMATION (REQUIRED)

Patient Name:_____ (Last) , _____ (First) **DOB:** _____ (MM) /_____ (DD) /_____ (YYYY) **Sex:** ☐ Male ☐ Female

Address: _____ **Phone:** _____ - _____ - _____

_____ **Collection Date:** ____ (MM) /____ (DD) /____ (YYYY) **Collection Time:** _____ (HH mm)

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Race: ☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Native Alaska ☐ Native Hawaiian/Pacific Islander

First Covid-19 test	☐ **Yes** ☐ **No**	
Healthcare Employee	☐ **Yes** ☐ **No**	
Symptomatic	☐ **Yes** ☐ **No**	*If symptomatic, please include symptom onset date* ____ (MM) /_____ (DD) /_____ (YYYY)
Hospitalized	☐ **Yes** ☐ **No**	
ICU Admit	☐ **Yes** ☐ **No**	
Congregated care resident	☐ **Yes** ☐ **No**	
Pregnant	☐ **Yes** ☐ **No**	

ORDERING PROVIDER (REQUIRED)

Clinic Name: _____

Phone: _____ - _____ - _____ **FAX:** _____ - _____ - _____ **Date:** _____ /_____ /_____

Ordering Provider Name & Credentials (NPI): _____

Clinician Signature (REQUIRED): _____

ICD-10 Code (REQUIRED):_____

(Common COVID-19 Codes) ☐ **Z11.59** Asymptomatic screening ☐ **Z01.818** Pre-surgical screening ☐ **Z20.828** Suspected exposure

BILLING INFORMATION

Bill To: ☐ **Patient** ☐ **Insurance** ☐ **Institutional**

Primary insurance:_____
Insurance ID#:_____
Primary insurance Group#:_____
Primary Insurance Subscriber:_____
Address:_____

City/State/Zip:_____
Phone:_____
Subscriber DOB:_____
Subscriber Name:_____
Relationship:_____

SPECIMEN INFORMATION (REQUIRED)

☐ **Saliva** ☐ **Nasopharyngeal Swab**

MOLECULAR BIOLOGY (REQUIRED)

☐ SARS-CoV-2/2019-nCoV (**COVID-19**) by NAA with probe detection.

ADDITIONAL INFORMATION / SPECIAL INSTRUCTIONS

Incomplete requisitions will have processing delays and may not qualify for next business day turnaround.