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COVID-19 TESTING REQUISITION FORM

PHYSICIAN'S INFORMATION

PATIENT'S INFORMATION

NAME (LAST, FIRST)		M.I.
GENDER ☐ MALE ☐ FEMALE	DOB (MM/DD/YY)	PHONE
EMAIL		PATIENT ID#
ADDRESS		
CITY	STATE	ZIP

SPECIMEN COLLECTION

DATE	
TIME	☐ AM ☐ PM

BILLING INFORMATION

☐ BILL PATIENT
☐ BILL CLIENT
☐ BILL INSURANCE

INSURANCE CO. NAME	SUBSCRIBER MEMBER#	GROUP#
INSURANCE ADDRESS	CITY	STATE / ZIP

COVID-19 TESTS

LEGEND: RF - Refrigerated | RT - Room Temperature

RT	94547-7 ☐ COVID TOTAL AB IgG/IgM	Specimen: SST
RF	94534-5 ☐ SARS-Cov2 RT-PCR	Specimen: SWAB

PLEASE ANSWER THE FOLLOWING QUESTIONS

FIRST TEST?
☐ YES ☐ NO

PREGNANT?
☐ YES ☐ NO

EMPLOYED IN HEALTHCARE?
☐ YES ☐ NO

SYMPTOMATIC?
☐ YES ☐ NO IF "YES" DATE: _____

HOSPITALIZED?
☐ YES ☐ NO

RACE
☐ WHITE
☐ BLACK OR AFRICAN AMERICAN
☐ ASIAN
☐ OTHER RACE
_____

ICU?
☐ YES ☐ NO

ETHNICITY
☐ HISPANIC ☐ NON-HISPANIC

RESIDENT IN CONGREGATE CARE SETTING?
☐ YES ☐ NO

COLLECTION SITE
☐ ANTERIOR NARES ☐ MID-TURBINATE ☐ NASOPHARYNGEAL

DIAGNOSES (ICD-10 CODES)

SIGNATURE _____ DATE _____