COVID-19 Molecular Test Requisition

INFORM DIAGNOSTICS

▶ ALL YELLOW FIELDS ARE REQUIRED

PATIENT INFORMATION

Last Name	First Name	M.I.

Date of Birth / /	Sex	Age	Patient ID # (Driver's License/State ID)

Race
☐ White ☐ Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Ethnicity
☐ Hispanic or Latino ☐ NOT Hispanic or Latino

Address

Address	County

City	State	Zip

Email Address	Phone #

Date of Collection / /	Time of Collection _____ AM PM

CLIENT INFORMATION

Account Number

Ordering Clinician

Does the patient work in the healthcare field?	☐ Yes	☐ No	☐ Unknown
Is the patient currently hospitalized?	☐ Yes	☐ No	
Is the patient in ICU?	☐ Yes	☐ No	
Is the patient pregnant?	☐ Yes (O98.519)	☐ No	☐ Unknown

Is the patient a resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelters, foster care or other setting)? ☐ Yes ☐ No

BILLING INFORMATION

Attach the Following: ▪ Copy of Front and Back of Insurance Card, if Applicable

Payor ☐ Medicare Part A or B ____ ☐ Insurance ☐ Patient ☐ Client ☐ Other _____

Pre-authorization Code

Place of Service
Required for Medicare

☐ Physician Office (11) ☐ Group Home (14) ☐ Hospital (Inpatient 21, Outpatient 22)
☐ Ambulatory Surgery Center (24) ☐ Place of Employment (18) ☐ Other _____
☐ Assisted Living (12) ☐ Skilled Nursing Facility (31) _____

INSURANCE INFORMATION

Insurance Carrier	Policy #/Insured ID #	Group #

Claims Address	Claims Phone #	Policy Holder's Name

Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent	Policy Holder's DOB / /	Policy Holder's Sex ☐ M ☐ F

Secondary Insurance (if available)	Policy #/Insured ID #	Group #

CLINICAL HISTORY Also attach copy of doctor's notes/clinical history

☐ Symptomatic patient with *confirmed/possible* exposure (Z20.822) (indicate symptoms below)
☐ Asymptomatic patient with *confirmed/possible* exposure (Z20.822)
☐ Screening for pre-op testing (Z20.822) (list any signs and symptoms below)
☐ Personal history of COVID-19 (Z86.19) (list any signs and symptoms below)

Check all symptoms: ☐ Body aches (R52) ☐ Bronchitis, acute/sub (J20.8) ☐ Bronchitis, chronic/NOS (J42) ☐ Bronchitis, unspec. (J40) ☐ Chest congestion (R09.89)
☐ Chills (R68.83) ☐ Chills w/fever (R50.9) ☐ Cough (R05) ☐ Diarrhea (R19.7) ☐ Fatigue (R53.83) ☐ Fever (R50.9) ☐ Headache (R51.9) ☐ Muscle aches (M79.10)
☐ Nausea (R11.0) ☐ Nausea w/vomiting (R11.2) ☐ New loss of taste/smell (R43.9) ☐ Runny nose (R09.89) ☐ SOB (R06.02) ☐ Sore throat (J02.9) ☐ Vomiting (R11.10)
Respiratory infection: ☐ Lower, acute (J22) ☐ Upper, acute (J06.9) ☐ Upper, chronic (J39.8) ☐ Other Respiratory Disorder (J98.8)

Other reason(s) for testing (including ICD codes) _____

(ICD guidelines indicate that U07.1 should only be used for a positive test result or if the patient had a previous positive result and is being retested.)

SPECIMEN INFORMATION

Swabs (please select swab type and transport media below)

☐ Nasopharyngeal (NP) ☐ Oropharyngeal (OP)
☐ Nasal Mid-Turbinate (NMT) ☐ Other _____
☐ Viral Transport Media (e.g. UTM®, UVT®) ☐ Sterile Saline

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☐ Saliva

TESTING

SARS-CoV-2 RT-PCR Test

☐ Initial Test ☐ Follow-up Test

REQUIREMENTS

Swab-Volume 1 mL OR Saliva
Shipping and Storage

- Multiple swabs from the same patient can be combined in a single vial for testing
- Store at 2–8° C and ship overnight on ice pack, or store frozen at -70° C and ship overnight on dry ice
- Do not leave specimen refrigerated more than 72 hours after collection
- Do not use calcium alginate tips, swabs with preservatives, or cotton swabs with wooden shafts
- Label specimen container with patient first and last name, and DOB
- Each specimen transport vial should be submitted with its own separate requisition and transported in its own sealed bag

Ordering clinician should enter the signs, symptoms and ICD-10 code(s) that best describe the reason(s) for performing the test.

Clinicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. In keeping with the requirements of Medicaid and Medicare, it is the policy of Inform Diagnostics only to perform testing that is medically necessary for the diagnosis and treatment of patient.

▶ Clinician Signature (Required) _____

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