pathline

01001

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SARS-CoV-2 Real-Time RT-PCR Requisition

PATIENT INFORMATION

Last Name	First Name	M.I.
Street Address		
City	State	Zip
Patient Phone Number	Patient Social Security Number	
Date of Birth	Age / Sex	Patient ID
Ethnicity		
Employer	Employer Phone #	

BILLING/INSURANCE (attach copy of insurance card – both sides)

Bill:
- ☐ Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Worker's Comp
- ☐ Patient
- ☐ Physician
- ☐ Hospital
- ☐ Other
- ☐ Outpatient/ Non-Hospital
- ☐ Hospital (IP/OP/ER)

Subscriber Insurance ☐ Secondary Insurance Info Attached

Subscriber Name/Relationship ☐ Self ☐ Spouse ☐ Dependent

Company Name

Address

City | State | Zip

Employer Name

Subscriber DOB | Group Contract # | Member ID #

Subscriber Sex ☐ M ☐ F | Medicare # | Medicaid ID #

CLIENT INFORMATION

(Please circle or write in Treating Physician name and NPI #)

Physician's Signature

X: _____

DATE/TIME COLLECTED D: _____/_____/_____ T: _____ AM PM

Send Duplicate of Report to:

Name: _____

☐Address: _____

ICD 10 CODE(S) (Required): _____

TEST REQUESTED

☐ SARS Coronavirus 2 Real-Time RT-PCR ☐ SARS Coronavirus 2 Real-Time RT-PCR and Influenza A & B ☐ Influenza A & B

SPECIMENS SUBMITTED (Check all that apply):

Specimen Types:

- ☐ Nasopharyngeal swab (NP) in 2-3ml Transport Media
- ☐ Oropharyngeal swab (OP) in 2-3ml Transport Media
- ☐ Dual Nasopharyngeal/Oropharyngeal (NP/OP) swab in 2-3ml Transport Media
- ☐ Bronchoaveolar lavage
- ☐ Other: _____

Collection Date: _____

CLINICAL HISTORY

Travel History within 14 days prior to illness onset: ☐ Yes ☐ No

Travel to: _____

Dates Of Travel: _____ Date of Return: _____

Clinical History

☐ Fever ☐ Cough ☐ Shortness of Breath ☐ Other _____

Date of Symptom Onset: _____ Patient is ☐ In-Patient ☐ Out-Patient

Did the patient die as result of illness ☐ Yes ☐ No

Did patient have contact with another COVID-19 case? ☐ Yes ☐ No ☐ Unknown If yes, was contact a U.S. Case? ☐ Yes ☐ No

01001 A _____	01001 B _____	01001 C _____	01001 D _____
01001 E _____	01001 F _____	01001 G _____	01001 H _____