PATHMD

YOUR PARTNER IN MOLECULAR TESTING

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COVID-19 REQUISITION

V.9.20

Accession Number
(Lab Use Only)

☐ PATIENT ☐ STAFF

REQUESTING PHYSICIAN OR BUSINESS ORGANIZATION

SUBMITTER ADDRESS (STREET NUMBER, NAME OF STREET) | CITY | STATE | ZIP CODE

CONTACT PERSON/CLINICIAN'S LAST NAME | TELEPHONE NUMBER | FAX | EMAIL ADDRESS

PATIENT INFORMATION:

☐ OK TO CONTACT PATIENT

PATIENT'S LAST NAME | FIRST NAME | MIDDLE NAME

STREET ADDRESS | APARTMENT/SUITE NUMBER

CITY | STATE | ZIP CODE

TELEPHONE NUMBER | BIRTHDAY (MM/DD/YYYY) | AGE

SEX
☐ MALE
☐ FEMALE
☐ OTHER

ETHNICITY
☐ HISPANIC
☐ NON-HISPANIC
☐ OTHER

RACE
☐ WHITE
☐ AFRICAN AMERICAN / BLACK
☐ NATIVE AMERICAN
☐ ASIAN / PACIFIC ISLANDER
☐ OTHER / UNKNOWN

PATIENT EMAIL ADDRESS

INSURANCE INFO:

POLICY MEMBER ID # | INSURANCE COMPANY

GROUP/POLICY # | INSURANCE COMPANY PHONE NUMBER

POLICY HOLDER LAST NAME | POLICY HOLDER FIRST NAME

TEST REQUEST INFORMATION:

DATE COLLECTED | TIME

TEST:

Source/Specimen Type (one source type per form)

☐ COVID-19 U0003
☐ NASAL SWAB
☐ NASOPHARYNGEAL SWAB
☐ OROPHARYNGEAL SWAB

ICD-10 CODES:

☐ Z03.818
Encounter for observation for suspected exposure to other biolgical agents ruled out. *(For cases where there is a concern for possible COVID-19 exposure)*

☐ Z20.828
Contact with and (suspected) exposure to other viral communicable diseases. *(Only to be used if actual exposure with someone confirmed to have COVID-19)*

I authorize PathMD, Inc. ("PathMD") and partners (the "Providers") to disclose my COVID-19 test results as between and among themselves with certain limitations listed below. The **purpose** of this Authorization is to assist Company in determining my fitness for duty, ability to return to work or shcool in a Company location during the COVID-19 outbreak. The **specific information that may be disclosed** under this Authorization includes my name, contact information and any results of COVID-19 tests performed to Company or its affiliates.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions. By my signature, I authorize PathMD and the Providers to use or disclose my health information in the manner described above.

SIGNATURE OF INDIVIDUAL (OR PARENT ON BEHALF OF MINOR) | **PRINTED NAME** | **DATE**

PATIENT / PHYSICIAN NAME
Parent or Guardian signature if patient is under 18 years of age.

PATIENT / PHYSICIAN SIGNATURE
By signature, I am providing consent for PathMD to perform COVID testing and to provide the results to the email provided above. I also acknowledge that I am 18 years or older and can make my medical decisions.