PATHMD

YOUR PARTNER IN MOLECULAR TESTING

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COVID-19 REQUISITION

V.7.20

Accession Number
(Lab Use Only)

REQUESTER INFORMATION:

REQUESTING PHYSICIAN OR BUSINESS ORGANIZATION

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

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

PATIENT INFORMATION:

PATIENT EMAIL ADDRESS

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

ETHNICITY
- ☐ HISPANIC
- ☐ NON-HISPANIC

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

ADDITIONAL EMAIL TO PROVIDE RESULTS

INSURANCE INFO:

RECIPIENT ID # | INSURANCE COMPANY

GROUP/POLICY # | INSURANCE COMPANY PHONE NUMBER

POLICY HOLDER LAST NAME | POLICY HOLDER FIRST NAME

ELIGIBILITY BEGIN DATE | ELIGIBILITY END DATE

TEST REQUEST INFORMATION:

DATE COLLECTED (MM/DD/YYYY) | TIME COLLECTED

- ☐ A.M.
- ☐ P.M.

TEST:

- ☐ COVID-19 U0003

Source/Specimen Type (one source type per form)
- ☐ 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)*

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