LABORATORY MEDICINE DIAGNOSTICS

COVID-19 TESTING REQUISITION FORM

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www.Lmdiagnostics.com **855 - 522 - 6334** 973 - 835 - 1739 Email: Lmdiagnostics@yahoo.com

Please Check One

- Asymptomatic (No Symptoms With Unknown Exposure) ☐
- Suspected Exposure (You Think You Were Exposed) ☐
- Contact with Suspected Exposure ☐
- Known Detection (Wants Re-Test) ☐

Office Use Only D____

R____ S____ ND____

Is the patient experiencing any of the following symptoms? ☐ Yes ☐ No ☐ Unknown

- Fever or chills
- Cough
- Sore Throat
- Shortness of Breath
- Headache
- Diarrhea
- Muscle or body aches
- Fatigue
- Congestion or runny nose
- Loss of Small and Taste
- Nausea or vomiting

If patient is symptomatic, what is the date of symptom onset? (mm/dd/yyyy) _____ / _____ / _____

Is patient a resident of a congregate care setting? ☐ Yes ☐ No ☐ Unknown

Is the patient employed in healthcare? ☐ Yes ☐ No ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Has the patient been hospitalized? ☐ Yes ☐ No ☐ Unknown

Is the patient in the ICU? ☐ Yes ☐ No ☐ Unknown

☐ COVID-19 Qualitative RT-PCR Testing ☐ COVID-19 IgM/IgG Serology Testing ☐ Other Testing: _____

Please print legibly.

SS# or ID# : _____

PATIENT INFORMATION / INSURANCE **Email:** _____

Patient's Name: _____ (Last), _____ (First) **Gender:** _____

Date of Birth: _____ / _____ / _____ **Race:** _____ **Ethnicity:** _____

Patient's Address: _____ **City / State:** _____

Zip Code: _____ **County:** _____ **Patient's Phone:** _____

Write Name of Insurance		Check Mark Insurance Type		*Office Use Only*
		Out of Network ____	Medicare ____	Diagnosis Code(s):
		Self-Pay ____	Medicaid ____	
Policy I.D.#		Workers Comp ____	Other: ___	
Group #		3rd Party Insurance ____		

I consent to having Laboratory Medicine Diagnostics analyze my sample(s) via which ever source is needed for testing. I acknowledge if my health insurance doesn't cover the test(s), I'm am responsible for payment.

Signature: **Date:**

SPECIMEN INFORMATION

COLLECTOR INITIALS

COLLECTION DATE: _____ **COLLECTION TIME:** _____

Specimen source (check one):

☐ Nasopharyngeal ☐ Oropharyngeal ☐ Serum ☐ Sputum ☐ Other: _____

MEDICAL FACILITY _____

Address: _____

Phone# _____ Fax #: _____

Requesting Clinician: _____ **NPI:** _____

Full Name (Last, First)

Provider ID : _____