PRINT FORM

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COVID-19 REQUISITION FORM

PLEASE SCAN TO SUBMIT THE FORM

ORDERING FACILITY

PATIENT'S INFORMATION

*THIS INFORMATION IS REQUIRED BY THE NEW YORK STATE DEPARTMENT OF HEALTH

PATIENT LAST NAME	FIRST NAME		MIDDLE
*STUDENT ☐ YES ☐ NO	*IF YES, WHICH SCHOOL?		
*EMPLOYED ☐ YES ☐ NO	*IF YES, WHERE? PLEASE INDICATE IF THE PLACE OF EMPLOYMENT IS A SCHOOL		
GENDER ☐ M ☐ F	DATE OF BIRTH (M/D/Y)	RACE	ETHNICITY
PHONE	ADDRESS		APT:#
CITY		STATE	ZIP

INSURANCE INFORMATION

INSURANCE COMPANY NAME	
ADDRESS	
CITY / STATE / ZIP	
PATIENT ID	
GROUP No #	
PATIENT RELATIONSHIP TO INSURED	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

BILLING INFORMATION

☐ INSURANCE ☐ MEDICAL PRACTICE ☐ MEDICARE
☐ PATIENT ☐ MEDICAID ☐ OTHER

SPECIMEN COLLECTION

ORDER DATE _____ ☐ STAT
COLLECTION DATE _____ TIME _____ ☐ AM ☐ PM
COLLECTOR NAME _____
☐ FAX REPORT _____ ☐ CALL RESULTS _____

RESPIRATORY

☐ **PCR**
Approved by FDA EUA
TEST CODE: **2023/2024**
SPECIMEN: **NP Swab**

☐ **ANTIGEN**
Approved by FDA EUA
TEST CODE: **202S**
SPECIMEN: **NP Swab**

☐ **RESPIRATORY SARS-COV-2 PANEL**
Approved by FDA EUA
TEST CODE: **2019**
SPECIMEN: **NP Swab**

SEROLOGY

☐ **SARS-COVID-19 ANTIBODIES**
THIS TEST IDENTIFIES TOTAL ANTIBODIES IgG and IgM
Approved by FDA EUA
TEST CODE: **2334**
SPECIMEN: **1 x SST**

☐ **SARS-COVID-19 ANTIBODIES**
THIS TEST IDENTIFIES IgG ANTIBODIES
Approved by FDA EUA
TEST CODE: **2030**
SPECIMEN: **1 x SST**

DIAGNOSES (ICD-10 CODES)

☐ **Z03.818**	Encounter for observation for suspected exposure to other biological agents ruled out
☐ **Z11.59**	Encounter for screening for other viral diseases

FRONT SIDE COPY

PATIENT'S DRIVER'S LICENSE OR LEGAL PHOTO ID (MANDATORY)

FRONT SIDE COPY

PATIENT'S INSURANCE CARD

PHYSICIAN'S SIGNATURE _____ DATE _____