



Laboratory Requisition
Patient Testing COVID-19

CLINICAL LABORATORIES
Phone: 513.636.7355
Fax: 513.636.3918
www.cincinnatichildrens.org/labs

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

PATIENT INFORMATION

Patient Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Medical Record Number: \_\_\_\_\_ Collection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Collection Time: \_\_\_\_\_ Priority:  Stat  Routine

Dx Description or ICD - Code (REQUIRED): \_\_\_\_\_ Bill To:  Self Pay  Insurance  Client (Client code: \_\_\_\_\_)

BILLING INFORMATION ORDERING PROVIDER

Insurance: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group No.: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Name/Rel.: \_\_\_\_\_

ORDERING PROVIDER

Ordering Provider Name & Credentials (Printed): \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Clinician Signature (REQUIRED) \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

MEDICAL NECESSITY REGULATIONS: At the government's request, the Clinical Laboratories would like to remind all physicians that when ordering tests expected to be paid under federal health care programs, such as Medicare and Medicaid, the tests must meet the following conditions: (1) included as covered services, (2) reasonable, (3) medically necessary for the treatment and diagnosis of the patient and (4) not for screening purposes.

PATIENT DEMOGRAPHICS

Race:  Black or African American  White  Hispanic/Latino  Asian
 American Indian  Middle Eastern  Alaska Native  Native Hawaiian and Other Pacific Islander
 Preferred Category Not Available  Refused  Unknown

Ethnicity:  Hispanic  Non-Hispanic  Unknown  Refused

Gender:  Male  Female If female: Currently pregnant?  No  Yes  Unknown

Is this the first COVID test?  No  Yes  Unknown

Is the patient in a group care facility?  No  Yes  Unknown

(Group home, foster care, homeless shelter, orphanage, detention facility, psychiatric facility, board and care home, substance abuse center)

Is the patient symptomatic?  No  Yes If yes, when did symptoms start? \_\_\_\_/\_\_\_\_/\_\_\_\_

TESTS INSTRUCTIONS:

- COVID-19 Test Molecular
 COVID-19 Ab Total Qualitative
 COVID-19 IgG Qualitative, Reflex to Quantitative
 COVID-19 IgG Qualitative, Reflex to Quantitative, IgA and IgM Qualitative

- 1. Complete the registration legibly with all information.
2. Use the swab provided in the test kit to collect a nasopharyngeal sample.
3. Label sample with the patient's full legal name and date of birth.
4. Send labeled sample and this requisition to the laboratory.
5. Once in the lab, send to lab registration team.

Name of person completing form: \_\_\_\_\_ Phone #: \_\_\_\_\_

