A DIVISION OF GENESIS CLINICAL DIAGNOSTICS
A MEMBER OF GENESIS BIOTECHNOLOGY GROUP

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CAP ACCREDITED
COLLEGE of AMERICAN PATHOLOGISTS

Coronavirus SARS-CoV-2 [COVID-19] Prepayment Test Requisition Form

Ordering Physician/Laboratory

(Required: Include the ordering physician's first & last name, NPI, practice name, complete address, phone number and fax number.)

Physician's Signature: | Date:

Physician to receive additional result report:

Patient Information (Please Print)

Name (Last, First) (Required):

In Care of:

Patient Address:

City: | State: | Zip:

Gender (Required): ☐ Female ☐ Male | Date of Birth (Required):

Patient SS#: | Patient ID#:

Phone Number: | Email:

Credit Card Information for Prepayment

☐ Check ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Make checks payable to Medical Diagnostic Laboratories.

Cardholder Name:

Cardholder Address:

Cardholder Phone

Account Number:

Amount to be charged:

Signature:

☐ Check box to have a receipt of payment mailed to cardholders address as listed above.

Specimen Information

Date Collected (Required):

Specimen Type:
☐ Serum

Test Selection

Serum Required. Stable at room temperature.

1138 ☐ SARS-CoV-2 IgG by quantitative ELISA* $195.00

Prepayment must be submitted with test requisition form. Testing will not be performed without prepayment.

* Test not available in New York.