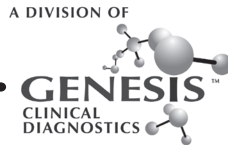

A MEMBER OF GENESIS BIOTECHNOLOGY GROUP

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New York Coronavirus SARS-CoV-2 [COVID-19] 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 (Required):

City (Required):	State (Required):	Zip (Required):

Gender (Required): ☐ Female ☐ Male ☐ Transgender ☐ Gender nonconforming	Date of Birth (Required):

Race (Required): ☐ African American/Black ☐ Asian ☐ Other: ☐ Caucasian ☐ Native American

Ethnicity (Required): ☐ Hispanic ☐ Non-Hispanic

Patient Phone Number (Required):

Patient SS#:	Patient ID#:

Email:

Employment/School Information (Required)**:**

☐ Student ☐ Volunteer ☐ Occupation (specify):____________________

Is your employer's information listed above in the ordering physician section? (Required)

☐ Yes ☐ No, please provide employer/school information below:

Employer/School Name (Required):

Employer/School Address (Required):

City (Required):	State (Required):	Zip (Required):

Employer Phone Number (Required):

Specimen Information

Date Collected (Required):	Specimen Type:	Specimen Source:
	☐ Swab (*please specify*): ☐ **COVID-*OneSwab*®** ☐ Saline ☐ UTM/VTM	☐ Nasopharyngeal ☐ Oropharyngeal ☐ Anterior Nares

Test Selection

Nasopharyngeal swab OR Oropharyngeal swab in COVID-*OneSwab*® vial

Test 1131, if not checked below, will be performed and billed.

1131 ☐ **SARS-CoV-2 [COVID-19] by Real-Time Reverse Transcription PCR (CDC N1, N2, RP targets)***

DIFFERENTIAL DIAGNOSIS & COINFECTIONS

***NasoSwab*® PEDIATRIC & ADULT Respiratory Infectious Diseases**
Tests by Real-Time PCR unless otherwise specified

319 ☐ *Chlamydophila pneumoniae*
1112 ☐ Group A Streptococcus
1118 ☐ MRSA: Methicillin Resistant and Methicillin Susceptible (MSSA) *Staphylococcus aureus* by Conventional PCR
1119 ☐ CA-MRSA: Community-Associated MRSA. Panton-Valentine Leukocidin (PVL) DNA**(Type IV MRSA + #1118 Req.) [Community Associated MRSA = Type IV MRSA+ and PVL+]

* The Wadsworth Center, New York State Department of Health has reviewed and approved this SARS-CoV-2 [COVID-19] by Real-Time Reverse Transcription PCR (CDC N1, N2, RP Targets).
** This test can only be performed when the test in parenthesis is positive. All tests performed will be billed.
OneSwab® and *NasoSwab*® are registered in the USPTO.
Physicians must only order tests that they have determined are medically necessary for the diagnosis and treatment of a patient. MDL offers individual tests, as well as a limited number of customized panels. If you choose to order a panel, please make certain that each and every test is medically necessary. If you check off a panel as your choice, MDL understands that the physician has determined that all of the component tests are medically necessary, and will perform, report and bill for all such component tests.

Other Tests/Panels:

Billing Information (Please include a copy of the front & back of card.)

	Relation (Required):	Diagnosis Codes (Required): Please provide ALL applicable diagnosis codes.
☐ Patient Billing	☐ Self	________ ________
☐ Insurance Billing	☐ Spouse	________ ________
☐ Path Lab/Hospital	☐ Dependant	
☐ Physician Account		

Primary Insurance Carrier:

Insured's Name (if not patient):

Insured's SS#:	Insured's DOB:

Claims Address:

Medicare, Medicaid or Policy ID#:

Employer/Group Name:	Group#: