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

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

☐ **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**

INSTRUCTIONS:

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 #: _____

Please reference the Test Directory/Index for tests not listed: www.cincinnatichildrens.org/labs

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