Woodhills Labs

# COVID-19 TESTING REQUISITION

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## PATIENT INFORMATION

First Name ______________________________

Last Name ______________________________

DOB ______/______/______ ❑ Male ❑ Female

Address ______________________________

City ________________ State _____ Zip ________

Email ________________ Phone ____________

❑ White ❑ Asian

❑ Black ❑ Native American

❑ Hispanic ❑ Other ____________

______________________________

## PROVIDER INFORMATION

Physician Name ______________________________

Facility Name ________________ NPI# ________

Address ________________ City ________

State _____ Zip ________ Phone ____________

Fax __________ Email ________________

## SPECIMEN COLLECTION

❑ **NP** ❑ **OP** ❑ **Nasal**

**Date of collection** / /

**Time of collection** : ❑ AM ❑ PM

## QUESTIONNAIRE

**ALL INFORMATION IS STRICTLY CONFIDENTIAL AND IS FOR USE WHEN DISGNOSING ILLNESS AMONG MEMBERS OF YOUR COMMUNITY**

State if you have the following symptoms:

1. Have you traveled internationally within 14 days?
   ☐ NO ☐ YES
2. Have you come into close contact with someone who has a laboratory confirmed COVID-19 diagnosis?
   ☐ NO ☐ YES
3. Do you have a fever (greater than 100.4 F or 38.0 C)?
   ☐ NO ☐ YES How Long ____________
4. Cough?
   ☐ NO ☐ YES How Long ____________
5. Shortness of breath?
   ☐ NO ☐ YES How Long ____________
6. Difficulty breathing?
   ☐ NO ☐ YES How Long ____________

## DIAGNOSIS CODE(S) FOR COVID-19

________ ________ ________ ________

________ ________ ________ ________

## INSURANCE RELEASE/CONSENT

**Consent/Insurance Release:** ❑ Self Pay

I voluntarily consent to the collection and testing of my specimen. I authorize the laboratory to release the result of this testing to the ordering facility, insurance company/federal/state/local authorities. Furthermore, I authorize my insurance benefits directly to Woodhills Labs for the services I receive. I will be responsible for any payments denied by the Insurance/Government or in case of self pay.

Signature: ________________ Date: ________

## ORDERING PHYSICIAN'S SIGNATURE

Signature: ________________ Date: ________

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