COVID AND FLU, RESPIRATORY REQUISITION FORM

MicroGen HEALTH
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Order Number:

Facility Name & Address	Requesting Physician	Collection Information: Date & Time Collected: MM / DD / YYYY Collected by (*Print*): _____

Patient Information REQUIRED: *Enclose a copy of the front and back of patient's insurance card(s), driver's license, and patient demographic.*

*Gender: ○ Male ○ Female ○ Others

*First Name: Middle Name: *Last Name: *Date of Birth: MM / DD / YYYY

*Address: *City: *State:

*Zip Code: *Phone: (Mandatory): *Email ID:

Payment Information ○ NO INSURANCE ○ Medicare ○ Medicaid ○ Ordering physician ○ Self pay ○ Direct Bill

○ **Primary Insurance**	Insurance company	Policyholder Name	Policy ID	Group ID
○ **Secondary Insurance**	Insurance company	Policyholder Name	Policy ID	Group ID

ICD-10 Diagnosis Code(s): Insurance companies require patient specific ICD-10 Codes to determine medical necessity

Sample Type ○ Oropharyngeal Swab ○ Nasopharyngeal Swab

Test Requested
○ RT-PCR Covid-19 ○ **Covid-19 and Influenza A+B RT-PCR**

If RT-PCR Covid 19 Negative run the below selected test
☐ Respiratory Pathogen Panel

○ **Respiratory Pathogen Panel**

- ☐ Bordetella pertussis
- ☐ Human Bocavirus
- ☐ Bordetella bronchiseptica/ parapertussis/pertussis
- ☐ Chlamydophila pneumoniae
- ☐ Human Coronavirus 229E
- ☐ Human Coronavirus HKU1
- ☐ Human Coronavirus NL63
- ☐ Human Coronavirus OC43
- ☐ Enterovirus D68
- ☐ Haemophilus influenzae,
- ☐ Human Respiratory Syncytial Virus B (RSVB),
- ☐ Streptococcus pneumoniae
- ☐ Human herpesvirus 3 (HHV3 - Varicella zoster Virus)
- ☐ Human herpesvirus 4 (HHV4 - Epstein-Barr Virus)
- ☐ Human herpesvirus 5 (HHV5 - Cytomegalovirus)
- ☐ Human herpesvirus 6 (HHV6)
- ☐ Human Metapneumovirus (hMPV)
- ☐ Influenza A/H1-2009
- ☐ Influenza A/H3
- ☐ Klebsiella pneumoniae
- ☐ Legionella pneumophila
- ☐ Mycoplasma pneumoniae
- ☐ Human Parainfluenza virus 1
- ☐ Human Parainfluenza virus 2
- ☐ Human Parainfluenza virus 3
- ☐ Human Parainfluenza virus 4
- ☐ Acinetobacter baumannii
- ☐ Streptococcus pyogenes
- ☐ Pseudomonas aeruginosa
- ☐ Moraxella catarrhalis
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Staphylococcus aureus
- ☐ Enterovirus pan
- ☐ Adenovirus 1/2
- ☐ Influenza B Virus
- ☐ Human Rhinovirus 1/2
- ☐ Human Rhinovirus 2/2
- ☐ Influenza A Virus pan
- ☐ Human Respiratory Syncytial Virus A (RSVA)
- ☐ Adenovirus 2/2

○ **ABR :** Fem A, Ure R, Methicillin 1

Symptoms:

Is the patient experiencing any of the following symptoms? ☐ Yes ☐ No ☐ Unknown **Date of symptom onset?** MM / DD / YYYY

- ☐ Fever or chills
- ☐ Cough
- ☐ Sore Throat
- ☐ Shortness of Breath
- ☐ Headache
- ☐ Diarrhea
- ☐ Muscle or body aches
- ☐ Fatigue
- ☐ Congestion or runny nose
- ☐ Loss of Smell and Taste
- ☐ Nausea or vomiting

Is patient a resident of a congregate care setting? ☐ Yes ☐ No ☐ Unknown

First Test: ○ Yes ○ No ○ Unknown
Employed in Healthcare: ○ Yes ○ No ○ Unknown
Symptomatic as defined by CDC: ○ Yes ○ No ○ Unknown
If Yes, Date of Symptom Onset (MM/DD/YY): _____
Hospitalized: ○ Yes ○ No ○ Unknown

ICU: ○ Yes ○ No ○ Unknown
Resident in a congregate care setting: ○ Yes ○ No ○ Unknown
Pregnant: ○ Yes ○ No ○ Unknown
Patient race: ○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Patient Islander ○ White ○ Other ○ Unknown
Patient Ethnicity: ○ Hispanic ○ Non Hispanic ○ Unknown

DISCLAIMER: NO COVID-19 DIAGNOSTIC TESTING IS GUARANTEED TO BE 100% ACCURATE AT THIS TIME. MICROGEN HEALTH DISCLAIMS RESPONSIBILITY FOR FALSE OR INACCURATE TEST RESULTS, INCLUDING WITHOUT LIMITATION, ANY FALSE NEGATIVE RESULTS WHICH MAY RESULT FROM SITUATIONS THAT INCLUDE BUT ARE NOT LIMITED TO: (I) TESTING PERFORMED PRIOR TO THE INCUBATION PERIOD OF COVID-19, WITH SUCH INCUBATION PERIOD PRESENTLY UNDERSTOOD TO BE THREE TO FIVE AND TWO-TENTHS (3 - 5.2) DAYS FOLLOWING AN INDIVIDUAL'S EXPOSURE; (II) INABILITY TO OBTAIN A GOOD SPECIMEN SOURCE FOR REASONS THAT MAY INCLUDE, BUT ARE NOT LIMITED TO, AN INDIVIDUAL BEING ASYMPTOMATIC, AND/OR THE SPECIMEN COLLECTION NOT FOLLOWING MICROGEN HEALTH INSTRUCTIONS; (III) THE LACK OF SUFFICIENT PRESENCE OF COVID-19 IN THE SPECIMEN BECAUSE THE VIRUS PRESENT IN THE INDIVIDUAL IS IN THE INCUBATION PERIOD, MEANING THE TESTED PERSON IS NOT SHEDDING COVID-19 AT THE TIME OF SPECIMEN COLLECTION; AND/OR (IV)) LABORATORY SENSITIVITY BEING UNABLE TO DETECT LOW VIRAL LOADS.

No test other than the specific Respiratory test ordered shall be performed on the biological sample and the sample shall be destroyed no more than fourteen days after the sample was taken, unless a longer period of retention is expressly authorized in a separate consent form.

I, the undersigned, understand I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing this authorization, I am acknowledging that payment(s) be made on my behalf to MicroGen Health for any services provided to me by MicroGen Health. I also allow the release of any medical information necessary to process claim.

Patient Signature: _____ Date: MM / DD / YYYY

Physician Signature: _____ Date: MM / DD / YYYY