MicroGen Health

CLIA # 49D2178444

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# COVID AND RESPIRATORY REQUISITION FORM

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Order Number:

| Facility Name & Address | Requesting Physician | Collection Information<br>date & time collected: _____<br>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.*

○ Male ○ Female

Last name | First name | Middle Initial | Date of Birth | Sex

**Address** | City | State | Zip Code

**Phone:** (mandatory)

Payment Information

○ **Insurance1**:
Insurance No: Group:

○ **Insurance2**:
Insurance No: Group: ○ Medicare ○ Medicaid ○ Ordering physician ○ Self pay ○ Direct Bill

Symptoms:

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

**Sample Type** ○ Oropharyngeal Swab ○ Nasopharyngeal Swab ○ Saliva

Test Requested

**Respiratory Pathogen Panel Targets**

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, Human Respiratory Syncytial Virus A (RSVA), Influenza A Virus pan, Adenovirus 2/2

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

**Tests:**

○ COVID19 ○ If COVID-19 Negative run the selected test ○ Respiratory Pathogen Panel

Serum test only, please collect in a serum separator tube (SST) and send spun down within 24 hours of collection.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| First Test: | ○ Yes | ○ No | ○ Unknown | ICU: | ○ Yes | ○ No | ○ Unknown |
| Employed in Healthcare: | ○ Yes | ○ No | ○ Unknown | Resident in a congregate care setting: | ○ Yes | ○ No | ○ Unknown |
| Symptomatic as defined by CDC: | ○ Yes | ○ No | ○ Unknown | Pregnant: | ○ Yes | ○ No | ○ Unknown |
| If Yes, Date of Symptom Onset (MM/DD/YY): | | | | Patient race: | ○ American Indian or Alaska Native | | |
| | | | | | ○ Asian | ○ Black or African American | |
| | | | | | ○ Native Hawaiian or Other Patient Islander | | |
| | | | | | ○ White | ○ Other | ○ Unknown |
| Hospitalized: | ○ Yes | ○ No | ○ Unknown | Patient Ethnicity: | ○ Hispanic | ○ Non Hispanic | ○ Unknown |

**DISCLAIMER:** NO COVID-19 DIAGNOSTIC TESTING IS GUARANTEED TO BE 100% ACCURATE AT THIS TIME. MICROGEN HEALTH INC 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 INC 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 sixty 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: _____

Physician Signature: _____ Date: _____