COVID-19, Influenza A/B REQUISITION FORM

promis DX

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CLIA #: 05D2185450 | CA License #: CDF-90000893

ID:

Specimen: Nasopharyngeal

PATIENT INFORMATION

Patient Name (First, Last): FIRST NAME _____ LAST NAME _____ **Date of Birth (YYYY/MM/DD):** _____ / _____ / _____

Address: _____ **Phone:** _____

City/State/Zip: _____ **Email:** _____

Collection Date: _____ **Time:** _____

BILLING INFORMATION

Insurance: _____

Subscriber ID: _____ **Group No:** _____

Address: _____

City/State/Zip: _____

Subscriber Name _____ **Subscriber DOB: (YYYY/MM/DD)** _____ / _____ / _____

PATIENT DEMOGRAPHICS

Gender: ☐ Male ☐ Female If female: **Currently pregnant?** ☐ No ☐ Yes

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Race: ☐ Black / African American ☐ White ☐ Asian ☐ Other races (or Undisclosed)

☐ American Indian / Native Alaskan ☐ Native Hawaiian / Pacific Islander

Is this the first COVID test? ☐ No ☐ Yes

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? (YYYY/MM/DD) _____/_____/_____

Name of person completing form: _____ Phone #: _____

Sign Here: _____

PLEASE ATTACH A COPY OF YOUR MEDICARE OR INSURANCE CARD WITH THIS TEST REQUISITION FORM

Driver License or ID SCAN:	**INSURANCE CARD SCAN:**

NOTE: Your Healthcare information will be kept confidential, any information that we collect about you on this form will be kept in our office