

Laboratory Requisition  
Patient Testing COVID-19

Attest Biosciences

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Patient Number  
(Lab Use Only)

PATIENT INFORMATION

Patient Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Sample Accession Number: \_\_\_\_\_ Collection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Collection Time: \_\_\_\_\_ Priority:  Stat  Routine  
Dx Description or ICD - Code (REQUIRED): \_\_\_\_\_ Bill To:  Self Pay  Insurance  Client (Client code: \_\_\_\_\_)

BILLING INFORMATION

ORDERING PROVIDER

Insurance: \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_ Group No.: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_  
Subscriber Name/Rel.: \_\_\_\_\_

Ordering Provider Name & Credentials (Printed):  
Stephen Anthony Huffman MD  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
On File  
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

INSTRUCTIONS:

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

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.

Name of person completing form: \_\_\_\_\_ Phone #: \_\_\_\_\_