Molecular Diagnostic Labs

1 833-219-7867 | moleculardxlabs@gmail.com | www.moleculardxlabs.com

COVID-19 Test Request Form

Please complete one form for each patient that COVID-19 testing is requested for. Include form with specimen submission.

REPORTER INFORMATION

Today's Date: ______________________________ Hospital/Clinic: ______________________________

Clinician Name: ______________________________ Phone: ______________________________

PATIENT INFORMATION

First Name: ____________________ Last Name: ____________________ Phone: ____________________

Address: ____ City: ____________________

Zip Code: ____________________ County: ____________________ State: ____________________

Date of Birth: ______/______/_______ Age: ____________ **Years/Months** Sex: ☐ **Male** ☐ **Female**

Additional information **required** for testing:

Does the patient work in a healthcare facility or congregate setting? (e.g., long-term care facility, shelter, prison, jail)

☐ **YES** ☐ **NO** Facility Name:______________________________

Employee Occupation:______________________________

Did the patient work while ill? ☐ **YES** ☐ **NO**

Does the patient live in a congregate setting? (e.g., long-term care facility, group home, prison, warehouse, restaurant)

☐ **YES** ☐ **NO** Facility or Company Name ______________________________

INSURANCE INFORMATION

Insurance:______________________________ ID #:______________________________ Group______________

Secoundry Insurance: ____________________ ID#:______________________________Group:______________

No Insunrace: ☐

CLINICAL INFORMATION

Date of symptom onset: ______/______/_______

Fever or Chills? ☐ Y ☐ N

Cough? ☐ Y ☐ N

Loss of Smell? ☐ Y ☐ N

Loss of Taste? ☐ Y ☐ N

Body Aches? ☐ Y ☐ N

Shortness of Breath? ☐ Y ☐ N

Fatigue? ☐ Y ☐ N

Sore Throat? ☐ Y ☐ N

Congestion or runny nose? ☐ Y ☐ N

Nausea, vomiting orDiarrhea? ☐ Y ☐ N

Does the patient have underlying conditions?

☐ None ☐ Immunocompromised

☐ Unknown ☐ Pregnant

☐ Diabetes ☐ Chronic Lung Disease

☐ Hypertension ☐ Chronic Liver Disease

☐ Cardiac Disease ☐ Chronic Kidney Disease

☐ Other:______________________________

Does the patient been in contact with other covid 19 patient

☐ Y ☐ N *If yes when:________

LABORATORY TESTING

☐ **YES** ☐ **NO** Has the patient been tested for antibodies?

Result: ☐ **Positive** ☐ **Negative**

Test Type: ☐ **Rapid Test** ☐ **PCR** ☐ **Blood**

Test Type Requested:

☐ **Rapid Antigen Test** ☐ **PCR** ☐ **Blood Antibodies**

COVID 2019 TESTING

Which specimen types

☐ NP ☐ OP ☐ Blood:____________ ☐ Other:________________ Specimen Collection Date:____________