InterScience
Diagnostic Laboratories, Inc.
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Staten Island, NY 10308
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CLIA I.D. 33D1082465

COVID-19 Requisition

CV- 18950

ACCOUNT INFORMATION

Requesting Physician: _____

Referring Physician: _____

Referring Physician Fax #: _____

Patient Chart #: _____

ICD-10 Code: _____

PATIENT INFORMATION

Last Name	First Name	M.I.
Street Address		
City	State	Zip Code
Phone	Sex / Patient Age	Date of Birth / /
Social Security #		

BILLING INFORMATION

BILL:
- ☐ Insurance
- ☐ Medicare
- ☐ Patient
- ☐ Client
- ☐ Secondary Insurance Information Attached

INCLUDE:
- ☐ Copy of the front and back of the patient's insurance dard

Name of Insured	Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent
Company Name	
Street Address	
City / State / Zip Code	
Employer Name	
Member ID #	Group Contract #
Medicare/Medicaid #	Referral #

☐ SARS-CoV-2 (COVID-19) Qualitative PCR

(ORF, E-gene, N-gene)

SAMPLE REQUIREMENTS & SHIPPING INSTRUCTIONS

a. Collect using standard procedure for selected collection type/kit.

b. Label each specimen with at least two unique identifiers that match the TRF (e.g. patient first and last name; DOB; MRN).

c. Store specimen in freezer or refrigerator prior to shipping.

d. Ship overnight within 24 hrs of collection (preferred method).

Note: Please insert all paperwork into the outside pocket of the specimen bag.

ICD-10 CODES

Select/Indicate ICD-10 code(s)

- ☐ Pneumonia (COVID-19) J12.89 Pneumonia, Other viral pneumonia B97.29 Pneumonia, Other coronavirus
- ☐ Lower Respiratory Infection (COVID-19) J22: Acute lower respiratory infection, Unspecified B97.29 Pneumonia, Other coronavirus
- ☐ Acute Bronchitis (COVID-19) J20.8 Acute Bronchitis, Unspecified B97.29 Pneumonia, Other coronavirus
- ☐ Bronchitis (COVID-19) J40 Bronchitis, Unspecified B97.29 Pneumonia, Other coronavirus
- ☐ Z03.818 Suspected exposure to COVID-19
- ☐ Z20.828 Known Exposure to COVID-19
- ☐ R05 Cough
- ☐ R06.02 Shortness of Breath
- ☐ R50.9 Fever, Unspecified
- ☐ J01.90 Acute Sinusitis, Unspecified
- ☐ J02.9 Acute Pharyngitis, Unspecified
- ☐ J06.9 Acute Upper Respiratory Infection, Unspecified
- ☐ J18.9 Pneumonia, Unspecified organism
- ☐ J20.9 Acute Bronchitis, Unspecified
- ☐ J32.9 Chronic Sinusitis, Unspecified
- ☐ Other:

Specimen Type:
- ☐ Nasopharyngeal Swab
- ☐ Sputum
- ☐ Bronchoalveolar Lavage
- ☐ Other: _____

Collection Date:

CLINICAL INFORMATION

Date of onset: (Month/Day/Year)

Hospitalized? ☐ Yes ☐ No

Date of admission: (Month/Day/Year)

Medical Record Number:

Severe Acute Lower Respiratory Illness:

☐ pneumonia **OR** ☐ ARDS

Check X-Ray/CT results:

Does the patient have the following signs and symptoms (check all that apply)?
- ☐ None
- ☐ Cough
- ☐ Shortness of breath
- ☐ Sore Throat
- ☐ Runny Nose
- ☐ Muscle Aches
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Headache
- ☐ Vomitting or nausea
- ☐ Fever (>100.4F or 38C)
- ☐ Subjective Fever
- ☐ Chills
- ☐ Other, Specify: _____
- ☐ Unknown

Pre-existing medical conditions (check all that apply):
- ☐ None
- ☐ Unknown
- ☐ Pregnancy
- ☐ Diabetes
- ☐ Hypertension
- ☐ Cardiovascular disease
- ☐ Chronic pulmonary disease
- ☐ Asthma
- ☐ Chronic renal disease
- ☐ Chronic liver disease
- ☐ Immunocompromised
- ☐ Neurologic disability
- ☐ Other: _____

HEALTHCARE PROVIDER AUTHORIZATION

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and company's patient informed consent. I agree to provide the company, or its designee, any and all additional information reasonably required for this testing to be performed.

Signature of Healthcare Provider: (Required) _____ Date: (Required) _____

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PLACE ON CV BAG 18950