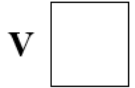




Northwell Health Laboratories
 450 Lakeville Road, Lake Success, NY 11042 | (516) 719-1100



Out-Patient - COVID-19 PCR Mandatory Test Requisition Form

PLACE LARGE LABORATORY LABEL BELOW AND COMPLETE ALL SECTIONS:

PATIENT INFORMATION FORM	PATIENT UNIQUE IDENTIFIER			PREGNANCY STATUS (IF APPLICABLE) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> NA		PHYSICIAN/OFFICE ACCOUNT #			
	NAME, LAST (Please Print)			FIRST M.I.		ORDERING PHYSICIAN NAME & NPI			
	BIRTHDATE		AGE	M/F	DATE/TIME COLLECTED		PHONE #		E-MAIL
	RACE: (Check All That Apply) <input type="checkbox"/> Black or African-American <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other				ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		ADDRESS/SUITE		
	STREET ADDRESS				PHONE #				
	CITY		STATE	ZIP	COUNTY		CITY		STATE ZIP
	PATIENT OCCUPATION			EMPLOYER NAME			EMPLOYEED IN HEALTHCARE WITH DIRECT PATIENT CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	EMPLOYER STREET ADDRESS			EMPLOYER PHONE #			IF YES PROVIDE TITLE		
	EMPLOYER CITY		EMP.STATE	EMP. ZIP CODE	EMP. COUNTY				
	BILLING	INSURANCE CARRIER NAME					ADDRESS		
INSURED NAME			PT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		INSURED ID #				
<input type="checkbox"/> MEDICARE #			<input type="checkbox"/> MEDICAID #		<input type="checkbox"/> SELF-PAY				

REQUIREMENTS:

1. Collect **Only One Nasopharyngeal Swab** in **One Vial** of Universal Transport Medium (UTM) Per Patient for **All Testing**: COVID-19 PCR and / or Molecular Respiratory Viral Testing.
2. **Mandatory Paper Test Form Required** – Otherwise Test Will Be **Rejected**.

ORDERABLES: COVID19 PCR COVID19 PCR & FLU A/B/RSV PCR RVP INCLUDING COVID19 PCR

<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> SKILLED NURSING FACILITY / ASSISTED LIVING FACILITY / REHABILITATION CENTER / HOSPICE CARE
FACILITY OR OFFICE NAME	FACILITY NAME

CLINICAL PRESENTATION / EPIDEMIOLOGIC RISK:

<input type="checkbox"/> SCREENING <input type="checkbox"/> SCHOOL SCREEN	<input type="checkbox"/> ASYMPTOMATIC	<input type="checkbox"/> SYMPTOMATIC WITH FLU LIKE SYMPTOMS / DATE: _____	<input type="checkbox"/> SYMPTOMATIC OTHER DATE: _____
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EXPOSURE RISK:

<input type="checkbox"/> CLOSE CONTACT WITH CONFIRMED COVID-19 CASE (LESS THAN 6FT CONTACT FOR > 10 MINUTES)	<input type="checkbox"/> ALL OTHER EXPOSURE TO CONFIRMED COVID-19 CASE (CLUSTERS / CASUAL CONTACT)
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SPECIAL CATEGORIES:

<input type="checkbox"/> NORTHWELL EHS REQUEST FOR CRITICAL HEALTHCARE PERSONNEL / ESSENTIAL WORKER / FIRST RESPONDER	<input type="checkbox"/> SURGERY DATE: _____
<input type="checkbox"/> OB - PRE-DELIVERY DATE: _____	<input type="checkbox"/> ONCOLOGY / PRE-TREATMENT
<input type="checkbox"/> PRE-PROCEDURE DATE: _____	<input type="checkbox"/> CLINICAL TRIAL