DIACARTA

CLIA ID#: 05D2110800

QuantiVirus™ SARS-CoV-2 Test Requisition Form

PART 1. PATIENT INFORMATION (REQUIRED)

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH

STREET ADDRESS | CITY | STATE | ZIP CODE

PREFERRED CONTACT PHONE NO.

☐ Home ☐ Mobile ☐ Work

GENDER

☐ Male ☐ Female ☐ Other

ETHNICITY IDENTIFICATION

☐ Hispanic or Latino
☐ Not Hispanic or Latino ☐ Unknown

RACE IDENTIFICATION

☐ African American ☐ Asian ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other

PART 2. SAMPLE COLLECTION TYPE (REQUIRED)

☐ Nasopharyngeal Swab ☐ Saliva Sample
☐ Nasal Swab ☐ Oropharyngeal Swab

COLLECTION DATE & TIME

SAMPLE COLLECTED BY

PART 3. PRACTICE/CLINIC INFORMATION (REQUIRED)

PRACTICE/CLINIC NAME

PHYSICIAN'S NPI NUMBER

PRACTICE/CLINIC STREET ADDRESS | CITY | STATE | ZIP CODE

EMAIL ADDRESS | PHONE NUMBER

PART 4. PHYSICIAN AUTHORIZATION / ICD-10 CODE(S) (REQUIRED)

☐ Exposure to COVID-19 Z20.828 ☐ Fever Z20.82 ☐ Pneumonia J12.89
☐ Viral Pneumonia B97.29 ☐ Acute Bronchitis J40,J20.8,B97.29

SIGNS & SYMPTOMS

☐ Coughing R05 ☐ Shortness of breath R06.02 ☐ Fever, unspecified R50.9 ☐ N/A

PHYSICIAN NAME

PHYSICIAN SIGNATURE

PART 5. PATIENT INSURANCE INFORMATION (REQUIRED FOR INSURANCE COVERAGE)

Where applicable please include a photocopy of insurance card(s) (both sides); for Credit Card please include a photocopy of a valid credit card (both sides).

PLEASE SELECT A BILLING OPTION & COMPLETE THE INFORMATION BELOW:

☐ Medicare ☐ Medicaid ☐ Insurance ☐ Credit Card ☐ Workers Comp/Auto/LOP ☐ Information Attached

PRIMARY INSURANCE CARRIER | PRIMARY INSURANCE ID NO. | PRIMARY INSURANCE GROUP NO.

PATIENT RELATIONSHIP TO INSURED

☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY INSURANCE CARRIER | SECONDARY INSURANCE ID NO. | SECONDARY INSURANCE GROUP NO.

PATIENT RELATIONSHIP TO INSURED

☐ Self ☐ Spouse ☐ Dependent ☐ Other

PART 6. PATIENT CONSENT

I _____(Patient or legal guardian name), request and authorize the DiaCarta Clinical Laboratory to perform the requested test(s) for the person(s) listed above. I acknowledge the benefits, risks, and limitations outlined below. I understand that my specimen(s) will be submitted to DiaCarta for the purpose of lab testing. I authorize DiaCarta to store my specimen in case additional testing is necessary. The DiaCarta Clinical Laboratory does not return patient samples. I can request additional tests or send out samples to other institutions if there is enough sample. Once my test result has been released, remaining samples may be de-identified to be used for laboratory quality control or research. I can withdraw my consent at any time by calling the DiaCarta laboratory at (800) 246-8878. My signature below indicates that I have read the above information. All my questions have been answered and my inquiries regarding the purpose of this test have been discussed and fully understood by me.

PATIENT NAME (PRINT)

PATIENT SIGNATURE

DATE

AFFIX SPECIMEN BARCODE HERE