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COVID-19 Test Requisition Form

Place Barcode Label Here

Collection Date: ____ / ____ / _____
Collection Time: ____ : ____ ☐ AM ☐ PM

PATIENT INFORMATION

Last Name:	First Name:	Date of Birth:
Email:	Phone:	Gender: ☐ M ☐ F
Address:	City: State:	Zip:

DIAGNOSIS CODES

☐ Z20.822: Contact with and (suspected) exposure to COVID-19	☐ Z03.818: Encounter or observation for suspected exposure to COVID-19	☐ Z11.52: Encounter for screening for COVID-19
☐ Z86.16: Personal history of COVID-19	☐ Z01.84: Encounter for antibody detection	☐ Z28.310: Unvaccinated
☐ Z28.311: Partially vaccinated for COVID-19	☐ J06.9: Acute respiratory infection	☐ J12.82: Other viral pneumonia
☐ J40: Bronchitis	☐ B97.21 SARS-associated virus as the cause of disease	☐ B34.2: Coronavirus infection
☐ R06.02: Shortness of breath	☐ R05: Cough	☐ R50.9: Fever
☐ R07.1: Chest pain on breathing	☐ R34.1: Disturbance in smell	☐ R09.3: Abnormal sputum

PATIENT CONSENT/AUTHORIZATION

- I hereby authorize the release of medical information related to this service for submission of personal reports to my healthcare providers and insurance carriers.
- In addition, I agree to assume responsibility for payment of charges for laboratory services that are not covered by my healthcare insurer.

Patient Signature: _____ **Date:** ____ / ____ / _____

INSURANCE AND PAYMENT INFORMATION

☐ Bill Insurance (attach copy of insurance card, front and back) ☐ Bill Client ☐ Bill Patient (Cash/Check/Credit Card) ☐ Other:

Primary Plan Name:	Policy Holder Name:
Policy #:	Group #:
Secondary Plan Name:	Policy Holder Name:
Policy #:	Group #:

HEALTHCARE PROVIDER INFORMATION

Provider Name:	NPI:	
Organization:	Phone:	
Address:	City: State:	Zip:

Provider Authorization Signature: _____ **Date:** ____ / ____ / _____

TEST MENU

PCR/GENETIC SEQUENCING

Specimen Type: ☐ Nasal swab ☐ Nasopharyngeal swab ☐ Cheek swab ☐ Saliva

☐ **RT-PCR**	☐ **RT-PCR with RNase kit**
☐ **Rapid RT-PCR**	☐ **Rapid RT-PCR for SARS-CoV-2, Influenza A, Influenza B, and RSV**

☐ **Sequencing for SARS-CoV-2 Variant Identification**

ANTIGEN/ANTIBODY

Specimen Type: ☐ Nasal swab ☐ Serum ☐ Plasma

☐ **Flowflex Rapid Antigen**	☐ **Neutralizing Antibody**
☐ **N Protein IgG/IgM**	☐ **N and S Protein IgG/IgM**

FOR LABORATORY USE ONLY

Accession #:	Patient ID:
Client/Physician ID:	Date Received: ____ / ____ / _____ Time Received: ____ : ____ ☐ AM ☐ PM

Please visit our webpage at virantdx.com/testing-solutions/covid-2/ and contact us at info@virantdx.com or (877) 888-2973 for any inquiries.