COVID-19 Testing Requisition
Internal Use

ST LAWRENCE HEALTH
An Affiliate of Rochester Regional Health

Patient Information

Last Name:_____

First Name:_____

DOB: _____ ☐ **Male** ☐ **Female**

Address: _____

City: _____ **State**: _____**Zip**: _____

IMPORTANT: Primary result notification is by phone. Please confirm patient phone number.

Patient Phone: _____

Patient Email:_____

Insurance: _____ **Policy ID**: _____

Subscriber: _____ **Relationship:** _____

Covid-19 Test Information

☐ **In-House Covid Test**
Nasopharyngeal swab submitted in transport media vial

☐ **Biofire Respiratory Panel 2.1**
Nasopharyngeal swab submitted in transport media vial
Required: Provider Order

☐ **Abbott ID Now:**
Nasopharyngeal swab: Dry: transport to lab within 30 minutes
Required: Admistrative Approval

☐ **Rapid Antigen:**
Nasopharyngeal swab: Dry: transport to lab within 30 minutes
Required: Admistrative Approval

Diagnosis

- ☐ Pre-operative……Z01.812
- ☐ Suspected……Z20.828
- ☐ Screening……Z11.59
- ☐ 39-Weeks OB…….Z3A.39
- ☐ Other:_____

Specimen Collection

Location:_____

Date:_____

Time:_____

Initials:_____

Peel off sticker

Last, First
DOB

Init:

Date Time:

Print Ordering Physician :_____ **Date**: _____

Physician Signature:_____

Send additional copies to:_____