Cleveland Clinic Laboratories

2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

RESPIRATORY VIRUS TEST REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name | First | MI

Address | Birth Date | Age | Sex ☐ M ☐ F

City | County

State | Zip | Home Phone (including area code)

Hospital/Physician Office Patient ID # | Accession #

ETHNICITY: ☐ Unknown (;Z) ☐ Hispanic (;H) ☐ Non-Hispanic (;N) ☐ Other (;O)

RACE: ☐ Unknown (;Z) ☐ White (;W) ☐ Black (;B) ☐ Asian (;A) ☐ Native American (;N)

IF PATIENT IS UNDER 16 YEARS OF AGE:

Name of guardian/parent

PLEASE COMPLETE THE FOLLOWING SECTION WHEN A COPY OF INSURANCE CARD (FRONT AND BACK) IS NOT PROVIDED.

PRIMARY: ☐ Medicare ☐ Medicaid (Ohio only) ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

SECONDARY: ☐ Medicare ☐ Medicaid (Ohio only) ☐ Other Ins. _____ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name | First | MI

Beneficiary / Member # | Group #

Claims Address | City | State | Zip

BILLING INSTRUCTIONS (MUST COMPLETE OR CLIENT WILL BE BILLED)

BILL TO: ☐ Client ☐ Patient ☐ Medicare ☐ Other Insurance

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes

1. _____ 2. _____ 3. _____

CLIENT INFORMATION

SAMPLE INFORMATION (REQUIRED)

Collection Date: ____/____/____ (mm dd yyyy) Time: _____

Collected by: _____

Specimen Type:
☐ Anterior Nares (Nasal) Swab
☐ Nasopharyngeal (NP) Swab

ITCOVD Testing Only:
☐ Aspirate, tracheal
☐ Bronchoalveolar Lavage (BAL)
☐ Sputum

PHYSICIAN INFORMATION (REQUIRED)

Physician Signature

Date / Time

Physician Name (please print)

Address

City, State, Zip

Phone (including area code) | UPIN

☐ Send additional report
Physician: _____
Address: _____
City, State, Zip: _____

☐ Call results to phone number: (_____) _____

☐ Fax report to: (_____) _____

MEDICAL NECESSITY NOTICE

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

CORONAVIRUS 2019: PATIENT DETAILS

Is the patient:
Symptomatic as defined by the CDC?
☐ Yes ☐ No

Date of Symptom Onset:
____/____/____
mm dd yyyy

INDICATE TESTS REQUESTED

UPPER & LOWER RESPIRATORY SPECIMENS
☐ COVID & Influenza A/B & RSV NAAT, Routine *CVFLRS*

UPPER RESPIRATORY SPECIMENS
☐ COVID & Influenza A/B, Routine *COVFLU*
☐ COVID NAAT, Upper Respiratory, Routine *COVID*

LOWER RESPIRATORY SPECIMENS
☐ COVID NAAT, Lower Respiratory, Routine *ITCOVID*

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