COVID-19/Respiratory Requisition Form

Lab Director: Thomas L. O'Rourke, MD CLIA#11D2212215
Address: 5380 P'tree Ind. Blvd., Ste 200 Norcross, Ga 30071
Tel: 770-807-0466/ Fax: 470-545-0405
Email: support@elinalabs.com

Clinic Name	Requesting Physician	Collection Information
		Date & Time Collected: _____ Collected by (print):_____

Patient Information

REQUIRED: *Enclose a copy of the front and back of patient's insurance card(s), driver's license, and patient demographic.*

Last First Middle Initial Date of Birth (MM/DD/YYYY) Sex: ❍ Male ❍ Female

_____

Address City State Zip

_____

Phone/ Email

_____

Ethnicity: ❍ African American ❍ Asian ❍ Caucasian ❍ Hispanic ❍ Other: _____

Payment Information

❍ Insurance ❍ Uninsured (Copy of License/ Social Security Required) ❍ Medicare (Part A) ❍ Medicare (Part B) ❍ Medicaid ❍ Client Bill ❍ Self-pay

Symptoms:

ICD-10 Diagnosis Code(s): Insurance companies require patient specific ICD-10 Codes to determine medical necessity.

_____ _____ _____ _____ _____

Sample Type

❍ Nasopharyngeal Swab (NP)

Test Requested

❍ **COVID-19** (SARS-CoV-2)

❍ **RPP** (Respiratory Panel)

Viral Target: Adenovirus, Coronavirus HKU1, Coronavirus NL63, Coronavirus 229E, Coronavirus OC43, Human Metapneumovirus, Human Rhinovirus/Enterovirus Influenza A, Influenza A/H1, Influenza A/H3, Influenza A/H1-2009, Influenza B, Parainfluenza Virus 1, Parainfluenza Virus 2 , Parainfluenza Virus 3, Parainfluenza Virus 4, Respiratory Syncytial Virus

Bacterial Target: Bordetella pertussis, Chlamydophila pneumoniae, Mycoplasma pneumoniae

No tests other than the specific Respiratory tests ordered shall be performed on the biological sample and the sample shall be destroyed no more than 30 days after the sample was taken, unless a longer period of retention is expressly authorized in a separate consent form.

All infectious diseases required by law to be reported will be reported to the Georgia Department of Health (DPH).

I, the undersigned, understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing this authorization, I am acknowledging that payment(s) be made on my behalf to Elina Labs for any services provided to me by Elina Labs. I also allow the release of any medical information necessary to process this claim.

Patient Signature:_____ Date: _____

STATEMENT OF MEDICAL NECESSITY
By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Physician Signature:_____ Date: _____