AMEDIX LABORATORY
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COVID-19 REQUISITION FORM

PLEASE SCAN TO SUBMIT THE FORM

PRINT FORM

ORDERING FACILITY

PATIENT'S INFORMATION

*THIS INFORMATION IS REQUIRED BY THE NEW YORK STATE DEPARTMENT OF HEALTH

PATIENT LAST NAME	FIRST NAME		MIDDLE
*STUDENT ☐ YES ☐ NO	*IF YES, WHICH SCHOOL?		
*EMPLOYED ☐ YES ☐ NO	*IF YES, WHERE? PLEASE INDICATE IF THE PLACE OF EMPLOYMENT IS A SCHOOL		
GENDER ☐ M ☐ F	DATE OF BIRTH (M/D/Y)	RACE	ETHNICITY
PHONE	ADDRESS		APT:#
CITY		STATE	ZIP

INSURANCE INFORMATION

INSURANCE COMPANY NAME	
ADDRESS	
CITY / STATE / ZIP	
PATIENT ID	
GROUP No #	
PATIENT RELATIONSHIP TO INSURED	☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

BILLING INFORMATION

☐ INSURANCE ☐ MEDICAL PRACTICE ☐ MEDICARE
☐ PATIENT ☐ MEDICAID ☐ OTHER

SPECIMEN COLLECTION

ORDER DATE _____ ☐ STAT

COLLECTION DATE _____ TIME _____ ☐ AM ☐ PM

COLLECTOR NAME _____

☐ FAX REPORT _____ ☐ CALL RESULTS _____

RESPIRATORY

☐ **SARS-COVID-19 PCR**
Approved by FDA EUA
TEST CODE: T1060
SPECIMEN: NP Swab

☐ **SARS-COVID-19 ANTIGEN**
Approved by FDA EUA
TEST CODE: T1061
SPECIMEN: NP Swab

☐ **SARS-COV-2 RESPIRATORY PANEL**
Approved by FDA EUA
TEST CODE: T1062
SPECIMEN: NP Swab

SEROLOGY

☐ **SARS-COVID-19 ANTIBODIES**
THIS TEST IDENTIFIES
TOTAL ANTIBODIES IgG and IgM
Approved by FDA EUA
TEST CODE: T1063
SPECIMEN: 1 x SST

☐ **SARS-COVID-19 ANTIBODIES**
THIS TEST IDENTIFIES
IgG ANTIBODIES
Approved by FDA EUA
TEST CODE: T1064
SPECIMEN: 1 x SST

DIAGNOSES (ICD-10 CODES)

☐ Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out
☐ Z11.59	Encounter for screening for other viral diseases

FRONT SIDE COPY

PATIENT'S DRIVER'S LICENSE OR LEGAL PHOTO ID (MANDATORY)

FRONT SIDE COPY

PATIENT'S INSURANCE CARD

CLEAR FORM

EMAIL FORM

PHYSICIAN'S SIGNATURE _____

DATE _____