

SARS-COV2 RT PCR LAB REQUISITION FORM

Collection Information		Patient Information	
Date of Collection: ____/____/____ <small>MM DD YY</small>		<i>(Affix patient label here)</i>	
Time of Collection: _____ AM/PM			
Sample Type*: <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Nasal Swab <small>*Samples must be in Viral or Universal Transport Media (VTM/UTM)</small>			
Indication for Study			
ICD-10 Diagnosis Codes: _____			
Send Report To			
Physician: Dr. _____		Additional Professional Report Recipients	
Institution: _____		Name: _____	
Office: _____		Institution: _____	
Phone: _____ Fax: _____		Office: _____	
E-mail: _____ @ _____		Phone: _____ Fax: _____	
		E-mail: _____ @ _____	
First-line Test Molecular Testing			
<input type="checkbox"/> Xpress	XPERT Express SARS-COV2 (RT PCR)		
		Patient Information	
Patient Race		Last Name, First Name _____	
<input type="checkbox"/> American Indian or Alaska Native		Date of Birth _____	
<input type="checkbox"/> Black or African American		Medical Record Number _____	
<input type="checkbox"/> White		Home Address _____ (street)	
<input type="checkbox"/> Asian		_____ (city)	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		_____ (state)	
<input type="checkbox"/> Other Race or Unknown		_____ (zip code)	
Patient Ethnicity		LAB USE ONLY	
<input type="checkbox"/> Not Hispanic or Latino		Genetics # _____	
<input type="checkbox"/> Hispanic or Latino		Lab/Specimen # _____	
<input type="checkbox"/> Unknown		Date/Time received _____	

DIRECTIONS:

- 1) Complete the above requisition form.
- 2) Collect one nasopharyngeal sample in viral transport media or universal transport media. Ship at room temperature within 24 hrs. of collection.