COVID-19 RNA AND ANTIBODY DETECTION REQUISITION FORM

EastGene Laboratories, Inc,
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PART A: Patient Information *(Required)*

Last Name:_____ First Name_____

Date of Birth:_____/_____/_____ Gender: M ☐ F☐

Address:_____

City_____ State_____ Zip Code _____

Social Security:_____ Phone #_____

PART B: Provider Information

Name of Provider_____, MD/DO/NP

Name of Facility_____

Address:_____

_____

Tel:_____ Fax:_____-

PART C: Indications/Clinical History: _____

_____

PART D: Insurance Billing Information:

No Insurance ___

Self-Pay ___

Or Send Bill to Insurance:

Name of Primary Insurance CO _____ Insured ID _____ Group # _____

Relationship to Insured Self ☐ Spouse ☐ Child ☐ Other ☐

Insured's Name _____ Insured Date of Birth _____/_____/_____

Insured's Phone #:_____ Insured's employer: _____

Please Attach: 1) A copy of the front/back of patient's insurance card(s) or 2) Printout patient demographics and insurance information from your EHR

PART E: TEST REQUESTED:

RNA (PCR) ___, antibody post- infection ___, antibody post -vaccination (antibody to S protein) ___

PART F: SPECIMEN INFORMATION :

Date collected: _____

Time collected: _____

Specimen type: Nasal swab ___, Saliva ___, blood ___

FOR LAB USE ONLY: *Receiving Date:* _____ *Accession#* _____