WAKE TOXICOLOGY
Confidence In Testing

COVID-19 Test Requisition Form

WAKE TOXICOLOGY LABORATORY LLC
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CLIA#: 34D2150941

Patient Information :	***Online Registration (Confirmation No):***		
Last Name*	**First Name***	**Middle Initial**	**Suffix**
Date of Birth* (MM/DD/YYYY)	**Sex*** [ ] Male [ ] Female [ ] Other	**Race/Ethnicity**	
Address :	**City***	**State***	**ZIP**
Email*	**Phone Number***		

**Required Information ; ** Final report will be sent to the email*

Submitter Information:	***Bill To:***
Hospital, Laboratory, or other Facility	[ ] Insurance [ ] Patient [ ] Provider or Business
Health Care Provider Name:	**Insurance Name :**
Address (include room) :	**Insurance ID:**
Primary Contact Name : *(If not the Health Care Provider)*	Insurance Group
Contact Number :	DL / SSN:

Specimen Information :

Reason for Submission* [ ] Diagnostic [ ] Sickness [ ] Contracted with COVID positive person
[ ] Screening [ ] Travel [ ] Possible Exposure to COVID positive person

Specimen Type
[ ] Sterile Container [ ] Blood Tube (Plasma, Serum or Whole Blood) [ ] Other (Specify)

Specimen Source
[ ] Nasopharyngeal (NP) [ ] Nasal (AN) [ ] Oropharyngeal (OP) [ ] Throat [ ] Other (Specify) :

Test Request*
[ ] SARS CoV-2 Molecular Test (RT-PCR) [ ] SARS CoV-2 IgG / IgM Antibody

Clinical Syntoms: YES / NO	**Diagnosis Codes :**
[ ] Fever, Cough, Runny Nose, Congestion, Shortness of Breath	[ ] Z11.59 Screening, No symptoms
[ ] Muscle pain, Body Aches, Headache	[ ] Z03.818 Screening, Possible exposure
[ ] Fatigue, Sore Throat, New Loss of Taste or Smell	[ ] Z20.828 Screening, Confirmed exposure
[ ] Possible Exposure to COVID positive person	
[ ] Contact with COVID positive person	
[ ] Nausea, Vomiting, Diarrhea	
[ ] Other	

Patient: I agree that Laboratory will furnish to my designated insurance carrier the information on this form necessary for reimbursement. I hereby authorize service be performed and assign that benefits be payable to Laboratory. I understand that if any insurer doesn't pay and denies the claim as an uncovered service, I am responsible for payment. I authorize my insurance benefits to be paid directly to the laboratory for services I received. The laboratory is authorized to bill my insurance provider and to receive payment of benefits for the tests. I further authorize the testing laboratory and my physician to release to my insurance provider any medical information necessary to this claim.

Patient Signature*:

Date of Collection* *(MM/DD/YY):*	**Time of Collection*:**