

Clinic/Facility Name: Loudoun County/Bolen Park – June 1, 2020

Account #: _____

Provider(s): Dr. David Goodfriend - 0101222260

Physician Name: _____

NPI #: _____



1 Industry Drive, Henderson, NC 27537

Phone: (252) 572-2795

Fax: (252) 572-4595

CLIA ID: 34D2141858



Information highlighted in RED is required. Patient should fill out Section 1 only.

COVID-19 REQUISITION

1. Patient Demographics

Last Name: _____		First Name: _____		MI: _____	Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Multi-Race <input type="checkbox"/> Native Hawaiian of Other Pacific Islande <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Refused to Answer
Date of Birth: _____		[REDACTED]			
Address: _____		City/State/Zipcode: _____			
Phone #: _____		Email Address: _____			
Guardian: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other (In Loco Parentis)		Phone #: _____			
Last Name: _____		First Name: _____		MI: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		

2. Specimen Collection Information

Collector Name: _____ Collection Date: ____/____/____

Collection Time: _____ Collection Procedure: Nasal Oral Nasopharyngeal

Do not order non-medically necessary tests

3. Test Selection and Diagnosis Code Selection

TEST TYPE: PCR ANTIBODY ANTIGEN

720100 COVID-19 SARS-COV-2 by RT-PCR U0003

COVID-19 DX CODES

- | | | | |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> R05
Cough | <input type="checkbox"/> R50.9
Fever, unspecifie | <input type="checkbox"/> Z03.818
Encounter for observation for suspected exposure to other biological agents ruled out | <input type="checkbox"/> Z20.828
Contact with and (suspected) exposure to other viral communicable diseases. |
| <input type="checkbox"/> R06.02
Shortness of Breath | <input type="checkbox"/> Z11.59
Encounter for screening for other viral diseases | <i>For cases where there is a concern for possible COVID-19 exposure</i> | <i>Only to be used if actual exposure with someone confirmed to have COVID-19</i> |

Consent/Insurance Release: I, the undersigned, understand and grant permission to Mako Medical Laboratories, LLC to bill my insurance for laboratory services provided. I understand that services provided may not be covered by my insurance. I further understand that I may be responsible for co-pays, deductibles, and any amount not covered by my insurer. By signing below, I acknowledge that payment may be made on my behalf to Mako Medical Laboratories, LLC. I hereby authorize the ordering physician and/or clinic to disclose any personal or medical information that may be needed to process claims related to services rendered by Mako Medical Laboratories, LLC and its affiliates including information that pertains to my participation in substance abuse treatment. I understand that my records may be protected under 42 CFR Part 2, under which I may revoke my consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires six (6) months after the date of program discharge.

Patient Signature: _____ Patient Signature On File

Provider Signature: _____