AppLabs™ Diagnostic Laboratory
708 Bigley Ave.
Charleston, VA 25302
CLIA # 51D2160356

COVID-19 NP Swab (PCR) Test Request Form

Please complete one form for each patient that COVID-19 testing is requested for. Include form with specimen submission.

REPORTER INFORMATION

Collection Date	Hospital/Clinic	Phone

Clinician Name	Clinician Signature

PATIENT INFORMATION

First Name	Last Name	Date of Birth

Address	City

State	Zip Code	SSN (**insured and uninsured patients**)	**OR**	Driver's License (**for uninsured patients only**)	DL Issue State

LEAVE BLANK WHEN PAYING WITH CASH

Phone	E-Mail	Sex ☐ Male ☐ Female	**DX CODES****

Race (mark all that apply)

☐ White ☐ American Indian/Alaska Native
☐ Black ☐ Native Hawaiian/Pacific Isle
☐ Asian ☐ Other

Ethnicity

☐ Hispanic or Latino Origin
☐ Non-Hispanic

DX CODES**

☐ Z11.59 (COVID Screening)
☐ Z20.828 (COVID Suspected)
☐ Z03.818 (COVID Exposure)
☐ Other:

INSURANCE (if applicable) FILL IN OR ATTACH INFORMATION

Insurer	Policy #

ADDITIONAL INFORMATION REQUIRED FOR TESTING

Does the patient work in a healthcare facility or congregate setting? (e.g., long-term care facility, shelter, prison, jail)

☐ YES ☐ NO

Does the patient live in a healthcare facility or congregate setting? (e.g., long-term care facility, shelter, prison, jail)

☐ YES ☐ NO

CLINICAL INFORMATION

☐ YES ☐ NO Is this the first time the patient has tested for COVID-19?

☐ YES ☐ NO Is the patient symptomatic? (see below)* If **YES**, date of symptom onset: _____/_____/_____

☐ YES ☐ NO Was the patient hospitalized at time of specimen collection?

☐ YES ☐ NO Was the patient in the ICU at time of specimen collection?

☐ YES ☐ NO Is the patient pregnant?

* Symtoms may appear **2-14 days after exposure to the virus.** Symptoms include

- ⇨ Fever or chills
- ⇨ Cough
- ⇨ Shortness of breath or difficulty breathing
- ⇨ Fatigue
- ⇨ Muscle or body aches
- ⇨ Diarrhea
- ⇨ Headache
- ⇨ New loss of taste or smell
- ⇨ Sore throat
- ⇨ Congestion or runny nose
- ⇨ Nausea or vomiting

**DX Codes explained

Z11.59 - Asymptomatic, no known exposure, results unknown or negative

Z20.828 – Contact with COVID-19, Suspected exposure

Z03.818 - Possible exposure to COVID-19, infection ruled out

PLEASE SIGN THE CONSENT FORM ON THE NEXT PAGE/OTHER SIDE

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read the following informed consent:

1. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab, as ordered by an authorized medical provider or public health official.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
4. I understand that I am not creating a patient relationship with Aspirar Medical Lab by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
5. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

Please carefully read and comply with the following statements:

1. I understand that I may be infected with the virus causing COVID-19 and that I meet criteria for isolation.
2. I agree that while I wait for my COVID-19 test results, I will remain in self-isolation.
3. I agree that if my COVID-19 test results are **positive**, I will remain isolated for **7 days** from this day of testing **OR** until at least **72 hours** after my symptoms have resolved, **whichever is longer.**
4. I agree that if my COVID-19 test results are **negative**, I will remain isolated until at least **72 hours** after my symptoms have resolved.
5. I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons.
6. I agree that I will not come into contact with any other person who is not isolated or ill due to potential COVID- 19 infection.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

_____ _____

Signature of patient/guardian Date

_____

Relationship to patient

FOR UNINSURED PATIENTS ONLY

I do not have health care coverage such as individual, employer-sponsored, Medicare or Medicaid coverage. Therefore, I affirm and attest the above patient qualifies as uninsured according to the COVID-19 Uninsured Program in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136).

_____ _____

Signature of patient/guardian Date

_____

Relationship to patient