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COVID-19 (RT-PCR) Test Form

Specimen Information				
Collection Date	**Collection Time**	**Fasting** ☐ Yes ☐ No	**STAT** ☐ Yes ☐ No	**Fax Results to if STAT**

Patient Information

Last Name	**First Name**	**Middle Initial**	**Gender** ☐ Male ☐ Female

Race ☐ Amer Ind /Alaskan ☐ Asian ☐ Black/Afr Amer ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other
Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Mailing Address	**City**	**State**	**Zip**
	Date of Birth *(MM-DD-YYYY)*		**Age**
Phone Number	**Email**		

BILLING/INSURANCE INFORMATION	☐ Cash Patient	☐ Bill Medicare	☐ Bill Insurance

Insurance Name
(Please attach a copy of the card)

Insurance ID:	**Relationship:** ☐ Self ☐ Spouse ☐ Dependent

Test (with Nasal SWAB Only): SARS Covid-19 RT-PCR

Related Diagnosis ICD-10 Codes: ☐ Z11.59: Encounter for screening for other viral diseases
☐ Z03.818: Encounter for observation for suspected exposure to other biological agents ruled out
☐ Z20.828: Contact with and (suspected) exposure to other viral communicable diseases

The following diagnosis codes may be appropriate as associated manifestations, regardless of confirmed COVID-19:
☐ R05: Cough ☐ R06.02: Shortness of breath ☐ R50.9: Fever, unspecified ☐ J12.89: Other viral pneumonia
☐ J20.8: Acute bronchitis due to other specified organisms ☐ J22: Unspecified acute lower respiratory infection
☐ J40: Bronchitis, nor specified as acute or chronic ☐ J80: Acute respiratory distress syndrome
☐ J96.01: Acute respiratory failure with hypoxia ☐ J98.8: Other specified respiratory disorders

COVID-19 TESTING – INFORMED CONSENT & PRIVACY PRACTICES

Please read carefully and sign the following Informed Consent & Notice of Privacy Practices

INFORMED CONSENT:

I authorize Avantic Medical Lab to collect and test for COVID-19 (SARS -COV -2) through a nasopharyngeal, nasal, or oral swab, as ordered by an authorized medical provider or public health official. I also understand that this procedure is semi-invasive and I may experience mild pain and discomfort and possible bleeding. I understand that this test detects if the SARS-COV-2 (the virus that causes COVID-19) is present at the time of testing only. It does not test for immunity of if the virus has been present in the past. I understand that Avantic Medical Lab is not acting as my medical provider, this testing does not replace treatment by my medical provider,and 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 persists or worsens. I understand that, as with any medical test, there is potential for a false positive or false negative COVID-19 test result. I authorize my information and results to be shared with the county, state or any other governmental entity which is requiredby law for COVID-19 tests.

PRIVACY PRACTICES:

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detailthe uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I mayexercise these rights and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request. I hereby acknowledge as the patient or parent/guardian, that I have read the above information and I grant consent for Avantic Medical Lab to perform COVID–19 testing as required, and report as noted above AND I acknowledge receipt of the practice's privacy policy.

Patient's Signature________________________________ Date______________