|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Requisition for COVID Testing**  **Fax this requisition to Marlborough Lab at fax number 508-229-1240** | | | | |
| **Patient Last Name: First Name:** | | | | |
| **Address:** | | | | |
| **DOB:** | | | **Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ X \_\_\_\_\_** | |
| **Patient phone number:** | | | | |
| **Patient’s Self-Reported Race(s) (Patient may select all that apply):**   * **American Indian or Alaska Native \_\_\_\_** * **Asian \_\_\_\_** * **Black or African American \_\_\_\_** * **Native Hawaiian or Pacific Islander \_\_\_\_** * **White \_\_\_\_** * **Other \_\_\_\_** * **Declined to Answer \_\_\_\_** | | | **Patient’s Self-Reported Hispanic Indicator:**   * **Hispanic or Latino \_\_\_\_** * **Not Hispanic or Latino \_\_\_\_** * **Declined to Answer \_\_\_\_** | |
| **Patient’s Self-Reported Ethnicity or Ethnic Background (i.e., American, Brazilian, Korean, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Declined to Answer \_\_\_\_** | |
| **Sample Collection Date:**  **Sample Collection Time:** | | | **Insurance Company / Guarantor / Submitter (if paid by an Employer):** | |
| **Ref. Office Fax:** | | | **Ref. Office Phone:** | |
| **Ordering Provider Name (please print):** | | | | |
| **Must provide one or more DX code:**   * **R06.02: Shortness of breath or difficulty breathing\_\_\_\_** * **R50.9: Fever (+100.0F), unspecified\_\_\_\_\_** * **R68.83: Chills without fever\_\_\_\_** * **R05: Cough \_\_\_\_** * **J02.9: Sore Throat\_\_\_** * **M79.18: Muscle Pain\_\_\_\_** * **G44.209: Headache, unspecified\_\_\_\_\_** * **R43.0: Loss of/ change in smell\_\_\_\_\_** * **Z20.828 Contact with and (suspected) exposure to other viral and communicable diseases.** | | | | |
|  |  |  | |  |
|  | **TEST** | **MNEMONIC** | | **SPEC TYPE** |
| **X** | **COVID -19 PCR (UMMHC)** | **LAB31815** | | **Saliva** |

**PLEASE PRINT CLEARLY**