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| **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.**
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|  |  |   |  |
|  | **TEST** | **MNEMONIC** | **SPEC TYPE** |
| **X** | **COVID -19 PCR (UMMHC)** | **LAB31815** | **Saliva** |

**PLEASE PRINT CLEARLY**