Please Place Barcode Label Here

Specimen Information

Time Collected

Date Collected

475 Knollcrest Drive Redding, CA 96002 • Phone: (877) 319-7222 • Fax: (530) 319-7225

PCR TEST REQUISITION for Sars-Cov-2 Test (Covid-19)

Test ordered by Dr. Kenneth Korver, MD. NPI# 1326159633 **Signature:** _____

Patient Information

Last Name

First Name *MI* ☐M ☐F *Gender*

Street Address

City *State* *Zip*

Date of Birth

Phone Number

Social Security #

Drivers License # and State of Issuance

Insurance Company Name - If cash pay please write Cash

Insurance Subscriber ID or Member ID

Responsible Party Name, if different from Patient

Information Required by the State of California for Covid-19 Tests:

Race:
- □White
- □Black or African American
- □American Indian or Alaska Native
- □Asian
- □Native Hawaiian or Other Pacific Islander
- □Other Race

Ethnicity:
- □Hispanic or Latino
- □Not Hispanic or Latino
- □Unknown

Preferred Language: _____

Patient Questionairre

☐Yes ☐No In the last 72 hours have you had a cough?

☐Yes ☐No In the last 72 hours have you experienced shortness of breath?

☐Yes ☐No In the last 72 hours have you had a fever?

☐Yes ☐No Have you been exposed to someone who is known or suspected of having Covid-19?

☐Yes ☐No Have you been sent by a medical facility? If yes, which facility? _____

Patient Acknowledgements

_____ *Initial* I am authorizing Lab24 to submit claims to Medicare, Medicaid, or third-party insurance companies.

_____ *Initial* I am requesting that Lab24, LLC release my results to myself by telephone.

Patient or Parent/Guardian Signature

If Parent/Guardian Signature - Relationship to Patient

Ordered Through Lassen County Public Health Department