632 Russell St. Covington, KY 41011
PH: 855-841-7111
CLIA# 18D1100471
Lab Director: Marc Rumpler, PhD.

Ordering Location Name: _____

Patient Information

Last Name: _____

First Name: _____

Sex: Male Female

Address: _____

City: _____

State: _____

Zip Code: _____

DOB: _____

Testing

☐ SARS-CoV-2

COLLECTION DATE: _____ COLLECTION TIME: _____

Specimen Type

☐ Nasopharyngeal with Liquid Amies
☐ Nasopharyngeal with VTM
☐ Nasopharyngeal with _____
☐ Other: _____

ICD-10 Code

☐ R05 – Cough

☐ R50.9 – Fever Unspecified

☐ R06.02 – Shortness of Breath

☐ Other: _____

My signature authorizes the providing laboratory to perform the above check-marked test(s) for the ICD-10 condition(s) identified. I certify based upon this patient's history, symptoms, examination findings and medical record that all ordered tests are medically necessary.

Physician Signature: _____