(Hosp. Use Only)

St Luke's HOSPITAL

OUTPATIENT LABORATORY REQUEST FORM

CEDAR CREST COLLEGE
Health Center Phone: (610) 606-4640

Med. Rec. #_____
Acct. #_____

ORDERING PHYSICIAN: Nancy Crane-Roberts, PhD, CRNP, RN

PATIENT NAME: _____ **DOB:** _____ **SEX:** _____

STREET: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____

PHONE NUMBER: _____

ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ST. LUKE'S HOSPITAL FOR MEDICAL INSURANCE BENEFITS, ON MY BEHALF, FOR SERVICES RENDERED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO BE RELEASED TO MEDICARE OR OTHER INSURER INFORMATION NEEDED TO DETERMINE ON THIS OR A RELATED CLAIM.

Patient's Signature: _____ Date: _____

ALL INFORMATION REQUIRED FOR ST. LUKE'S TO ACCEPT INSURANCE ASSIGNMENT

_____ Blue Cross/Blue Shield _____ Medicaid/Medicare # _____

_____ Other (specify) _____

Name of Plan: _____ Policyholder:_____

Policy Number:_____ Group Number: _____

Patient Relationship to Policyholder: _____Self _____Spouse _____Child

SPECIMEN COLLECTION DATE: _____ **SPECIMEN COLLECTION TIME:** _____

ICD10 CODE(S): _____**Z11.59**_____

TEST(S) REQUESTED:

	☐ **Lab30135 Novel Coronavirus (Covid-19) *Nasal*** ☐ Lab30135 Novel Coronavirus (Covid-19) *Oropharyngeal* ☐ Lab30135 Novel Coronavirus (Covid-19) *Nasopharyngeal*		

1. Does the patient currently work in a healthcare setting with direct patient contact? ___yes ___no
2. Symptomatic for COVID-19 as defined by CDC? ___yes ___no
   If yes, when did your symptoms begin? _____
3. Are you currently pregnant? ___yes ___no
4. Does the patient currently reside in a congregate (group) care setting? _X__yes ___no
5. Is this the first test you have had for COVID-19? ___yes ___no
6. Hospitalized for COVID-19? ___yes _X__no
7. Is the individual in an ICU for COVID-19? ___yes _X_

Physician's Signature: *Nancy Crane-Roberts, PhD, CRNP, RN*