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Comprehensive Respiratory Requisition

Physician Information

Patient Information

Patient Name: _____
(Last Name, First Name)

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____ / ____ / ____ Phone#: _____

Gender: Male Female SS#: _____

Requesting Physician's Signature

X _____

Collection Information

Collection Date: ____ / ____ / ____ Time: ____ am/pm

Collection Site: Office Home ASC Urgent Care Hospital

Race & Ethnicity

American Indian or Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander
 Hispanic Non-Hispanic White Refused Unknown Other: _____

Billing Information (Please attach copies of all cards, front and back)

PRIMARY Billing Information Attached

Medicare Medicaid Other Insurance Self Pay Bill Ordering Physician (no insurance info needed)

Insurance Carrier: _____ Policy/ID #: _____ Group #: _____

SECONDARY

Other Insurance: _____

Note: The following diagnosis codes are listed as a convenience only. Ordering physicians are **REQUIRED** to use the ICD-10 code that best describes the reason for performing the test, whether or not that code is listed below.

Upper Respiratory Pathogen Panel (RP2.1) with COVID-19 (see list on back)

Upper Respiratory ICD-10	
<input type="checkbox"/> B34.1	Enterovirus infection, unspecified
<input type="checkbox"/> B34.2	Coronavirus, unspecified
<input type="checkbox"/> J06.9	Acute upper respiratory infection, unspecified
<input type="checkbox"/> J22	Unspecified acute lower respiratory infection
<input type="checkbox"/> B97.81	Human metapneumovirus
<input type="checkbox"/> A37.90	Whooping cough
<input type="checkbox"/> A37.00	Whooping cough due to Bordetella pertussis
<input type="checkbox"/> A37.01	Whooping cough due to Bordetella pertussis with pneumonia
<input type="checkbox"/> J16.0	Chlamydial pneumonia
<input type="checkbox"/> B96.0	Mycoplasma pneumonia
<input type="checkbox"/> Other	_____

COVID-19 ONLY (PCR)

COVID-19 (SCREENING) ICD-10	
<input type="checkbox"/> Z03.818	Encounter for observation for suspected exposure to other biological agents ruled out (possible exposure to COVID-19)
<input type="checkbox"/> Z11.59	Encounter for screening for other viral diseases (asymptomatic)
<input type="checkbox"/> Z01.818	Encounter for preprocedural examination
<input type="checkbox"/> Z20.828	Contact with and (suspected) exposure to other viral communicable (confirmed exposure to COVID-19)
<input type="checkbox"/> Other	_____

COVID-19 (SYMPTOM) ICD-10	
<input type="checkbox"/> R05	Cough
<input type="checkbox"/> R06.02	Shortness of breath
<input type="checkbox"/> R50.9	Fever Unspecified
<input type="checkbox"/> J11.1	Flu Like Symptoms
<input type="checkbox"/> J06.9	Acute upper respiratory infection, unspecified
<input type="checkbox"/> J02.9	Pharyngitis, unspecified
<input type="checkbox"/> J20.8	Acute bronchitis due to other specified organisms
<input type="checkbox"/> J12.89	Other viral pneumonia
<input type="checkbox"/> J22	Unspecified acute lower respiratory infection
<input type="checkbox"/> Other	_____

SPECIMEN REQUISITION & LABEL INSTRUCTIONS:

1. Fully complete requisition form with all required information.
2. Complete specimen label with patients date of birth and full name.
3. Remove label and place barcoded label VERTICALLY on the specimen vial (not on the lid)

* Please ensure the patients date of birth and full name is indicated so that both the label and requisition match. Two patient identifiers are required on each specimen submitted. The unique barcode identifies the patient with this requisition form.

COVID-19 (Antibody)

Upper Respiratory Tests

RSV Only Flu A/B Only Flu A/B & RSV

FOR UNINSURED PATIENTS: If you want A2Z Diagnostics to bill the CARES ACT Provider Relief Fund for uninsured patients, you **MUST** provide the following information. Patient Social Security State Driver License State ID

I have verified and attest to the best of my knowledge that this patient does not have coverage through an individual, employer-sponsored plan, Federal Employee Health Benefits Program, federal health program, Medicare or Medicaid, and no other payer will reimburse for COVID-19 antibody testing at the time the test was ordered: YES NO

Specimens will not be processed without a Health Care Providers signature and ICD-10 code

Upper Respiratory Pathogen Panel (RP2.1) with COVID-19

BACTERIA

- Bordetella pertussis
- Chlamydia pneumoniae
- Mycoplasma pneumoniae
- Bordetella parapertussis

VIRUSES

- Adenovirus
- Coronavirus HKU1
- Coronavirus NL63
- Coronavirus 229E
- Coronavirus OC43
- Coronavirus SARS-CoV-2
- Human Metapneumovirus
- Human Rhinovirus/Enterovirus
- Influenza A
- Influenza A/H1
- Influenza A/H3
- Influenza A/H1-2009
- Influenza B
- Parainfluenza Virus 1
- Parainfluenza Virus 2
- Parainfluenza Virus 3
- Parainfluenza Virus 4
- Respiratory Syncytial Virus