LABORATORY TEST REQUISITION

BD Veritor System for Rapid Detection of SARS-CoV2 Antigen in Respiratory System *20200707*

LEXINGTON PRESCRIPTION CENTER
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LEXINGTON Rx CENTER
800 South Main St., Lexington 463-9166

PATIENT INFORMATION

NAME: Last First M.I.			**Specimen ID:**
Date of Birth / Age:	**Sex:** M F	**Home Phone:**	**Cell Phone:**

ADDRESS: Street City County State Zip Code

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black / African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐ Other

Ethnicity:	**When do you think you were exposed to Covid -19?**	**Are you currently experiencing symptoms? Y N** **Date of symptom onset?**

Symptoms (symptoms may occur 2-14 days after exposure to the virus)

Check all that apply: ☐ Fever or Chills ☐ Cough ☐ Shortness of breath or difficulty breathing ☐ Fatigue ☐ Muscle or body aches ☐ Headaches ☐ New loss of taste or smell ☐ Sore throat ☐ Congestion or runny nose ☐ Nausea or vomiting ☐ Diarrhea ☐ No symptoms

Please answer the following questions by circling the correct answer: ***Y(yes) N (no) U (unknown)***

1. **Is this your first COVID test? Y N U**
2. **Are you employed in Healthcare? Y N U**
3. **Were you hospitalized? Y N U**
4. **Were you in the ICU? Y N U**
5. **Were you a resident in a congregate care setting (nursing home, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter foster care or other setting? Y N U**
6. **Are you pregnant? Y N U**

PHYSICIAN INFORMATION (Optional)

Practice Name:	
Practitioner:	
Address:	
Phone #:	**Fax #:**

CONSENT AND RELEASE

☐ ***I have read, and I understand the "Fact Sheet for Patients" provided to me.***

☐ ***In consideration of my participation in this test, I hereby agree to assume all risks. I also understand that results are not designed to replace the care or advice of a medical provider. I understand that if I receive abnormal laboratory test results, I should promptly consult with a physician.***
To agree to participate in this test, please sign and date this form. Thank you.

Signature of participant, or parent or legal guardian if participant is under 18 years of age	**Printed name of participant, or parent or legal guardian**	**Date**

For Lab use only:

SPECIMEN COLLECTION INFORMATION

COLLECTION: Date Time Initials	**SPECIMEN SOURCE:** ***Double swab of internal nose (SCT)***	**REMARKS:**

SARS-CoV2 TEST RESULTS

Testing date: **Tested by:** **Remarks:**

☐ **Presumptive negative test for SARS-CoV-2 (no antigen detected)** *260415000*

☐ **Positive test for SARS-CoV-2 (antigen present)** *260373001*

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Payment Information:

Patient Name: _____ Date of Birth: _____

Name on Credit Card: _____

CC#: _____

Exp: _____ CVV: _____ Billing Zip Code: _____

Visa Mastercard American Express Discover Debit Card

By singing below, I authorize Lexington Prescription Center to charge the credit card/ debit card information I have provided. I also affirm that I have been made aware Lexington Prescription Center does not submit claims to insurance for COVID-19 tests and I am responsible for seeking reimbursement.

Signature: _____ Date: _____

Vehicle Description:

Make: _____

Model: _____

Color: _____