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CLIA#-05D2068755

Medical Director: | Bisma Siddiqui M.D..


UNIQUE REQUISITION ID

Org # 607 Location #609

[X] Dr #607 – Silverstein, Joseph

PATIENT INFORMATION			
PATIENT LAST NAME	FIRST	M.I	
PATIENT ADDRESS PLEASE ATTACH PATIENT DEMOGRAPHICS			
CITY	STATE	ZIP CODE	PHONE
PATIENT I.D.	SEX M F	DATE OF BIRTH	AGE
PHYSICIAN AUTHORIZATION / NAME:		NPI	
X			

<input type="checkbox"/> FASTING <input type="checkbox"/> STAT	COLLECTED BY:	DATE COLLECTED: / /	TIME COLLECTED: @ : AM/PM
BILL TO: MISSING BILLING INFORMATION WILL RESULT IN A DELAY			
<input type="checkbox"/> PATIENT	<input type="checkbox"/> DOCTOR / CLIENT	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> VENIPUNCTURE
<input type="checkbox"/> MEDICARE	<input type="checkbox"/> MEDICAID / MEDI-CAL	<input type="checkbox"/> CASH / CREDIT	<input type="checkbox"/> TRAVEL Mi.
<b>Ethnicity</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <b>Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Tagalog <input type="checkbox"/> Other <b>Race</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other			

 **#999 - SARS-CoV-2 (COVID-19) BY RT-PCR** [ ] - Z03.818 Suspected exposure to COVID-19 [ ] - Z20.828 Known Exposure to COVID-19

**\*\*\*REQUIRED: Attach insurance information and driver's license (insurance card front & back)\*\*\***

Email: \_\_\_\_\_

- HAVE YOU HAD ANY COVID EXPOSURE TO YOUR KNOWLEDGE? : Y / N
- DO YOU HAVE ANY OF THE FOLLOWING SXS:
  - FEVER? Y / N
  - COUGH? Y / N
  - SHORTNESS OF BREATH? Y / N
  - CHANGES IN TASTE OR SMELL? Y / N
  - CHILLS / FATIGUE? Y / N
- HAVE YOU TRAVELED OUTSIDE THE STATE IN THE LAST 14 DAYS? Y / N
- HAVE YOU TRAVELED OUTSIDE THE COUNTRY IN THE LAST 14 DAYS? Y / N
- DO YOU HAVE ANY SIGNIFICANT MEDICAL ISSUES SUCH AS HIGH BLOOD PRESSURE, DIABETES, COPD, CANCER, IMMUNE SYSTEM PROBLEMS? Y / N
- PLEASE LIST MEDICAL PROBLEMS: \_\_\_\_\_

I am the parent or legal guardian of the minor listed as Patient herein. I authorize Orange County Labs, Inc. (OC Lab) to conduct a Covid 19 test on my child. I further authorize OC Lab to release test results to the School identified above for its required reporting and for the determination of my child's athletic eligibility.



PARENT SIGNATURE

DATE

I HEREBY AUTHORIZE THE ABOVE ORDERED TESTING AND I ALLOW THE RELEASE OF ANY MEDICAL INFORMATION FOR PAYMENT TO OC LABS.



PATIENT SIGNATURE REQUIRED

DATE

SS \_\_\_\_\_ RED \_\_\_\_\_ LAV \_\_\_\_\_ Grey \_\_\_\_\_ Blue \_\_\_\_\_ Yellow \_\_\_\_\_ PAP \_\_\_\_\_ Bx \_\_\_\_\_ STOOL (Orange) SWAB \_\_\_\_\_ NASAL (Red) SWAB \_\_\_\_\_ SALIVA SWAB \_\_\_\_\_ UA TUBE \_\_\_\_\_

ORANGE COUNTY LABS, INC. - WHITE | PHYSICIAN COPY - PINK