Omega Bioservices
Your lab partner in research and diagnosis

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COVID19/RPP Test Requisition Form

Please complete one form for each patient and include the form with specimen submission.

PHYSICIAN INFORMATION

Physician: ______________________ Hospital/Clinic: ______________________
Date: ____________ Phone: ________________ Email: ________________

PATIENT INFORMATION

First Name: _____________ Last Name: ______________ Phone: _______________
Date of Birth: ____________ Gender: _________ Ethnic: __________________
Address: ____
City: _______________ State: _________ Zip Code: _________________
Insurance: _________________________ Insurance card #: ________________________
Additional information required for testing:
Does the patient work in healthcare or congregate setting? (e.g., nursing home, shelter, prison)
☐ Yes ☐ No If Yes, Facility Name: _____________________ Occupation: _________
Did the patient work while ill? ☐ Yes ☐ No
Does the patient live in a congregate setting? (e.g., nursing home, shelter, prison)
☐ Yes ☐ No If Yes, Facility Name: _________________________________
Does the patient receive dialysis? ☐ Yes ☐ No
Does the patient work in a dialysis facility? ☐ Yes ☐ No
Was the patient exposed to COVID-19 in the past 10 days? ☐ Yes ☐ No

TEST REQUEST

☐ COVID-19 Nucleic Acid (PCR)
☐ COVID-19 Variation (NGS)
☐ RPP

Specimen Source:
☐ Nasopharyngeal Swab ☐ Blood
☐ Saliva ☐ Others: ________________

Specimen Collection Date: __________________

CLINICAL INFORMATION

Does the patient have respiratory symptoms?
☐ Yes ☐ No If Yes, Since when: ________
Is the patient hospitalized?
☐ Yes ☐ No If Yes, Admit Date: ________
Hospital Name: _____________________
☐ Yes ☐ No ICU Admission?
☐ Yes ☐ No Intubated?
☐ Yes ☐ No Deceased?
☐ Yes ☐ No Chest X-ray or CT?
☐ Yes ☐ No ECMO?

Does the patient have underlying conditions
☐ None ☐ Unknown conditions
☐ Pregnant ☐ Immunocompromised
☐ Diabetes ☐ Chronic Lung Disease
☐ Hypertension ☐ Chronic Liver Disease
☐ Cardiac Disease ☐ Chronic Kidney Disease
☐ Others: ______________________
Has the patient been tested for any viral respiratory illness before? ☐ Yes ☐ No
If Yes, Results: ___________________

Physician/Practitioner: _________________________ Date: ____________________