

Patient Test Requisition

DevLab bio

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CLIA #: 45D2187554

Dir.: Aaron LeFebvre, PhD

Patient Information

Date of Requisition *

Patient Name *

Date of Birth *

Sex *

Male Female

Address *

Apartment/Suite

City *

State *

Zip *

County (Required for COVID-19 Reporting) *

Patient Email

Primary Phone *

Cell Phone

Race (Required for COVID-19 Reporting) *

- (AI) American Indian or Alaska Native
- (A) Asian
- (B) Black or African American
- (PI) Native Hawaiian or Other Pacific Islander
- (W) White (O) Other
- (U) Unknown

Ethnicity (Required for COVID-19 Reporting) *

- (H) Hispanic
- (NH) Non-Hispanic
- (U) Unknown

Patient Picture ID Photo

Parent/Guardian Picture ID Photo (if required)

Ordered Test & Specimen Collection

Collection Date *

Collection Time *

AM/PM *

AM PM

ICD-10 Code(s) - Diagnosis/Symptoms

Note: COVID-19 screening (Z11.59) is not covered by patient insurance plans; patients are ultimately responsible for payment for such testing if provided by the laboratory.

Select Ordered Test(s)

- SARS-CoV-2 Real-Time RT-PCR (SC2-P)
- SARS-CoV-2 IgG/IgM Antibody, Rapid (SC2-RA)

Select Specimen Type(s)

- Nasal/Anterior Nares Swab (NAS)
- Serum Separator (SST)
- Nasopharyngeal Swab (NPS)

U07.1; COVID-19, virus identified

Z03.818; Encounter for observation for suspected exposure to other biological agents ruled out

Z20.828; Contact with and (suspected) exposure to other viral communicable diseases

Z11.59; Encounter for screening for other viral diseases

J12.89; Other viral pneumonia

J20.8; Acute bronchitis due to other specified organisms

J40; Bronchitis, not specified as acute or chronic

J22; Unspecified acute lower respiratory infection

J98.8; Other specified respiratory disorders

J80; Acute respiratory distress syndrome

R05; Cough

R06.02; Shortness of breath

R50.9; Fever, unspecified

O98.5; Other viral diseases complicating pregnancy, childbirth and the puerperium

Z01.818; Encounter for other preprocedural examination

Other; Enter ICD-10 Code(s)

Patient Insurance Information

Payment Type

Account Bill Patient Bill Medicare Insurance

Insurance Carrier (if Insurance Payment Type selected)

Primary Policy Holder Name

Primary Policy Holder Date of Birth

Insurance Card Upload

Healthcare Provider Information

Name of Practice *

HYPOSPADIAS SPECIALTY CENTER

Physician Name *

WARREN T. SNODGRASS, NICOL C. BUSH


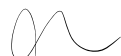
NPI

WTS: 1366411803

NCB:1568664332

Ordering Individual (if different than Physician)

Physician (or Ordering Individual) Signature *


WARREN T. SNODGRASS


NICOL C. BUSH