Cleveland Clinic Laboratories
2119 E. 93rd / L15
Cleveland, OH 44106
216.444.5755 or 800.628.6816

RESPIRATORY VIRUS TEST REQUISITION

<<FORM_ID>>

PATIENT INFORMATION (PLEASE PRINT IN BLACK INK)

Last Name ______ First ______ MI ______

Address ______ Birth Date ______ Age ______ Sex ☐ M ☐ F

City ______ County ______

State ______ Zip ______ Home Phone (including area code) ______

Hospital/Physician Office Patient ID # ______ Accession # ______

ETHNICITY: ☐ Unknown (;Z) ☐ Hispanic (;H) ☐ Non-Hispanic (;N) ☐ Other (;O)

RACE: ☐ Unknown (;Z) ☐ White (;W) ☐ Black (;B) ☐ Asian (;A) ☐ Native American (;N)

IF PATIENT IS UNDER 16 YEARS OF AGE:

Name of guardian/parent ______

PLEASE COMPLETE THE FOLLOWING SECTION WHEN A COPY OF INSURANCE CARD (FRONT AND BACK) IS NOT PROVIDED.

PRIMARY: ☐ Medicare ☐ Medicaid (Ohio only) ☐ Other Ins. ______ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name ______ First ______ MI ______

Beneficiary / Member # ______ Group # ______

Claims Address ______ City ______ State ______ Zip ______

SECONDARY: ☐ Medicare ☐ Medicaid (Ohio only) ☐ Other Ins. ______ ☐ Self ☐ Spouse ☐ Child

Subscriber Last Name ______ First ______ MI ______

Beneficiary / Member # ______ Group # ______

Claims Address ______ City ______ State ______ Zip ______

BILLING INSTRUCTIONS (MUST COMPLETE OR CLIENT WILL BE BILLED)

BILL TO: ☐ Client ☐ Patient ☐ Medicare ☐ Other Insurance

DIAGNOSIS CODE (REQUIRED) ICD-10 Codes

1. ______ 2. ______ 3. ______

CLIENT INFORMATION

SAMPLE INFORMATION (REQUIRED)

Collection Date: ____/____/____ (mm dd yyyy) Time: ______

Collected by: ______

Specimen Type:

☐ Anterior Nares (Nasal) Swab
☐ Nasopharyngeal (NP) Swab
☐ Aspirate, tracheal
☐ Bronchoalveolar Lavage (BAL)
☐ Sputum

PHYSICIAN INFORMATION (REQUIRED)

Physician Signature ______

Date / Time ______

Physician Name (please print) ______

Address ______

City, State, Zip ______

Phone (including area code) ______ UPIN ______

☐ Send additional report
Physician: ______
Address: ______
City, State, Zip: ______

☐ Call results to phone number: (______) ______

☐ Fax report to: (______) ______

MEDICAL NECESSITY NOTICE

When ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

INDICATE TESTS REQUESTED

RESPIRATORY VIRUS TESTING

☐ COVID & Influenza A/B & RSV NAAT, Routine *CVFLRS*

☐ Expanded Respiratory Pathogen Panel by PCR (with COVID), Routine *RPPCR*

Note: This test should rarely be ordered in the outpatient setting, and if ordered, preauthorization should be strongly considered. The test is very expensive, and if not covered by insurance, the patient will incur a substantial charge.

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