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 critical results to: (_____) _____

☐ 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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