MOLECULAR DIAGNOSTICS LABORATORY

UT Health San Antonio

Dept. of Pathology & Lab Medicine
Room 344B, Medical School Bldg.
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San Antonio, TX 78229-39000
https://lsom.uthscsa.edu/pathology/reference-labs/molecular-diagnostics-laboratory/

STRLClientServices@uthscsa.edu
(210) 567-6599
(210) 450-2243 (Fax)

Place patient hospital/clinic sticker here.

Patient Name: First (Middle Initial) Last DOB: Sex: Ethnicity:

Patient Phone: Patient Address: Street City State Zip

Ordering Facility: Address: Street City State Zip

Ordering Facility Phone: Collection Date & Time:

Patient ID#: Specimen #: Epic MRN:

Requesting Provider (required): First (Middle Initial) Last Phone: Fax:

Provider Address: Provider Email:

Diagnosis Code (check all that apply)

- ☐ Suspected exposure to COVID-19 (Z20.828)
- ☐ Screening for COVID-19 (Z11.59)
- ☐ Cough (R05)
- ☐ Shortness of breath (R06.02)
- ☐ Fever (R50.9)

Required Questions (answer all with Y/N/U)

- ☐ Is this the patient's first COVID-19 test? (yes/no/unknown)
- ☐ Is the patient employed in healthcare? (yes/no/unknown)
- ☐ Is the patient symptomatic? (yes/no/unknown)
- ☐ If symptomatic, date of symptom onset?
- ☐ Is the patient hospitalized? (yes/no/unknown)
- ☐ Is the patient in the ICU? (yes/no/unknown)
- ☐ Is the patient a resident in a congregate care setting?
- ☐ Is the patient pregnant? (yes/no/unknown)

Tests Requested (check all that apply)

- ☐ COVID-19 (SARS-COV-2) Nucleic Acid Test, Nasopharyngeal
- ☐ Other _____

Note: Specimens will not be processed without billing information

☐ ***Bill Facility:*** Facility Name Address Patient ID#

☐ ***Bill Patient:*** Guarantor Name Address Phone

☐ ***Bill Insurance:*** Insurance Company Name Insurance Company Address

Name of Insured Policy # Group #

Patient Address Telephone # Date of Birth

☐ ***Bill Research Account:*** Principal Investigator Account #