Molecular Vision Laboratory Requisition Form for COVID-19 Diagnostic Testing

1920 NE Stucki Ave, Ste. 150, Hillsboro OR 97006 | P: 503-227-3179 | F: 503-227-3157 | inquiry@mvisionlab.com

Patient Information

Last Name:	**First Name**:
DOB:	**Email:**
Gender: ☐ Male ☐ Female	**Parent Name** (if patient is a minor):
Phone Number:	

COVID-19 History

In the last 14 days, have you experienced any COVID-19 symptoms? (Listed below)
☐ Yes ☐ No

If yes, please indicate which symptoms (Check all that apply)
☐ Fever above 100°F ☐ Chills ☐ Cough, shortness of breath, or difficulty breathing
☐ Fatigue ☐ Muscle or body aches ☐ Headache ☐ New loss of taste or smell
☐ Sore throat ☐ Congestion or runny nose ☐ Nausea or vomiting ☐ Diarrhea

Have you been in close contact with a known COVID-19 positive person or someone exhibiting any of the above symptoms? ☐ Yes ☐ No

Clinic/Physician Information

Name: **Signature:** **Order Date:**	**Send Results to:** ☐ **Fax:** _____ ☐ **Email:** _____ **Please sign below if you give MVL the consent to release report directly to the patient:**

MVL USE ONLY

Sample Type: ☐ Saliva ☐ NP swab **Date collected**:
Time collected: _____

Test collection supervised by:_____ **from** _____
(initials) (organization)

Molecular Vision Laboratory informed consent for COVID-19 testing

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Patient Consent

Please carefully read the following informed consent

1. I authorize Molecular Vision Laboratory to conduct diagnostic testing on the sample I have provided for SARS-CoV-2, the virus causing COVID-19.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.
4. I understand that I am not creating a patient relationship with Molecular Vision Laboratory by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
5. I understand that, as with any medical test, there is the potential for false positive or false negative test.
6. I understand that if positive, my sample may be sent to another laboratory to confirm this result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

_____ _____

Signature of patient/guardian Date

Molecular Vision Laboratory Billing Information for COVID-19 diagnostic testing

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Credit Card Billing Information

Please note that you will need to pay an additional charge of $50 to obtain a doctor's prescription to run the test. We will provide you with instructions for this payment when you submit your sample.

Please provide select your requested turn around time and provide your billing information for the diagnostic test.

☐ Same day report service - Result by the end of day of sample collection ($150)
☐ Next day report service - Result by the end of the day on next day of sample collection ($99)

Name (as it appears on card):_____

Billing Address: _____

_____

Phone: _____ Email:_____

☐ Mastercard ☐ Visa ☐ American Express ☐ Other

Account/Card Number: _____

Security Code (4-digit number for American Express):_____
Exp Date: _____

Please bill my credit card the amount indicated above for diagnostic laboratory test performed by Molecular Vision Laboratory.

_____ _____

Signature of cardholder Date

Please note that Prescription Service at MVL ($50) must be paid directly to the doctor on -site, so please bring cash/personal check or pay by Paypal on-site.

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Institutional and Sponsor Billing Information

Accounts are charged upon receipt. Payment is expected within 90 days of invoice date.

PO#/Dept. Code: _____

Hospital/Clinic/Lab/Institution Name: _____

Contact Name: _____

Address: _____

City:_____

Phone:_____ Fax: _____

Institutional Billing Stamp