

# 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

<b>Name:</b>	<b>DOB:</b>	<b>Gender:</b>
<b>Address:</b>		
<b>Email:</b>	<b>Phone:</b>	Main Alt
<b>Parent Name:</b> (if patient is a minor):		
<b>Test Requested:</b>	<b>Reason for Test:</b>	
<input type="checkbox"/> RT-PCR Molecular testing	<input type="checkbox"/> Contact with known COVID-19 person	
<input type="checkbox"/> IgM Antibody testing	<input type="checkbox"/> Symptomatic	
	<input type="checkbox"/> Travel to _____ leaving on _____ State or country Date, time	

## 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  Headache  
 Muscle or body aches  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

<b>Name:</b>	<b>Send Results to:</b>
<b>Signature:</b>	<input type="checkbox"/> Fax: _____
<b>Order Date:</b>	<input type="checkbox"/> Email: _____
	<b>Please sign below if you give MVL the consent to release report directly to the patient:</b>

## MVL USE ONLY

<b>Sample Type:</b> <input type="checkbox"/> Saliva <input type="checkbox"/> NP swab <input type="checkbox"/> Blood	<b>Date collected:</b> _____
	<b>Time collected:</b> _____ (24 hr)
<b>Test collection supervised by:</b> _____ <b>from</b> _____ (initials) (organization)	

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## REALD INFORMATION

REALD is an effort to increase and standardize, Race, Ethnicity, Language, and Disability data collection across the Department of Human Services (DHS) and the Oregon Health Authority (OHA). REALD was advanced through the passage of House Bill 2134 passed by the Oregon legislature in 2013.

Your responses completely voluntary and confidential. They may be shared with OHA if we need to report your results to OHS. If you do not wish to provide an answer or feel uncomfortable doing so, you can indicate "Declined to answer".

## Race and Ethnicity

- How do you self-identify your race, ethnicity, country of origin, or ancestry?
- Which of the following describes you racial or ethnic identity? Please check ALL that apply.

<b>Hispanic or Latino/a/x</b> <input type="checkbox"/> Central American <input type="checkbox"/> Mexican <input type="checkbox"/> South American <input type="checkbox"/> Other Hispanic or Latino/a/x	<b>American Indian or Alaskan Native</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Canadian Inuit, Metis, or First Nation <input type="checkbox"/> Indigenous Mexican, Central American, or South American	<b>Asian</b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Communities of Myanmar <input type="checkbox"/> Filipino/a <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> South Asian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian
<b>Native Hawaiian or Pacific Islander</b> <input type="checkbox"/> Chamoru (Chamorro) <input type="checkbox"/> Marshallese <input type="checkbox"/> Communities of the Micronesian Region <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander	<b>Black or African American</b> <input type="checkbox"/> African American <input type="checkbox"/> Afro-Caribbean <input type="checkbox"/> Ethiopian <input type="checkbox"/> Somali <input type="checkbox"/> Other African (Black) <input type="checkbox"/> Other Black	<b>Other Categories</b> <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to answer
<b>White</b> <input type="checkbox"/> Eastern European <input type="checkbox"/> Slavic <input type="checkbox"/> Western European <input type="checkbox"/> Other White	<b>Middle Eastern/Northern African</b> <input type="checkbox"/> Northern African <input type="checkbox"/> Middle Eastern	

## Language

- In what language do you want to verbally communicate in?
- What language do you want written communications?
- If other than English was indicated for 3 or 4, do you want or need an interpreter to communicate with you?  
 Yes  No  Unknown  Declined
- If yes, what type of interpreter is preferred?  
 Spoken language interpreter  American Sign Language Interpreter  Deaf Interpreter for DeafBlind and with additional barriers  Contact sign language (PSE) interpreter
- How well do you speak English?  
 Very well  Well  Not Well  Not at all  Unknown  Declined

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## Disability

8. Do you have serious difficulty walking or climbing stairs?  Yes at age \_\_\_\_\_  No  Unknown  Declined
9. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?  Yes at age \_\_\_\_\_  No  Unknown  Declined
10. Do you have difficulty dressing or bathing?  Yes at age \_\_\_\_\_  No  Unknown  Declined
11. Do you have serious difficulty learning how to do things most people their age can learn?  
 Yes at age \_\_\_\_\_  No  Unknown  Declined
12. Using your usual (customary) language, do you have serious difficulty communicating?  
 Yes at age \_\_\_\_\_  No  Unknown  Declined

## SOGI

13. What first and last name do you want to use?
14. What pronouns do you use? Check all that apply  
 She/her  He/Him  They/Them  Ella  Él  Elles  No pronouns, use my name  
 Specify: \_\_\_\_\_  Don't know  I don't know what this question is asking  Declined to answer
15. How do you describe your gender? Check all that apply  
 Woman or Girl  Man or Boy  Agender/No gender  Feminine leaning  Masculine leaning  
 Non-binary  Questioning  Specify: \_\_\_\_\_  Don't know  I don't know what this question is asking  Declined to answer
16. Are you transgender?  
 Yes  No  Specify: \_\_\_\_\_  Don't know  I don't know what this question is asking  Declined to answer
17. How do you describe your sexual orientation or sexual identity?  
 Same-Gender Loving  Lesbian  Gay  Bisexual  Straight  Pansexual  Asexual  
 Queer  Questioning  Specify: \_\_\_\_\_  Don't know  I don't know what this question is asking  Declined to answer

# 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 \$35 to obtain a doctor's prescription through us 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 (\$150) - Result within 6 hours (must have sample by 9am)
- Next day report service (\$99) - Result within 26 hours

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 (\$35) 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