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

Name: Last , First **DOB**: MM/DD/YYYY **Gender:**

Address:

Email: **Phone:** Main

Alt

Parent Name: (if patient is a minor):

Test Requested:

☐ IgM Antibody testing ($50)

☐ RT-PCR Molecular testing

For RT-PCR, select turn around time:

☐ same day ($150) ☐ next day ($99)

Reason for Test:

☐ Contact with known COVID-19 person

☐ Symptomatic

☐ Travel to_____ leaving on _____

State or country Date

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

☐ **CHECK HERE IF USING MVL PRESCRIPTION SERVICE ($35)**

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 ☐ Blood

Date collected:

Time collected: _____ (24 hr)

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

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

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

Language

3. In what language do you want to verbally communicate in?

4. What language do you want written communications?

5. 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

6. 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

7. 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