OSF HEALTHCARE

COVID-19 Laboratory Test Requisition

REQUISITION MUST BE FILLED OUT COMPLETELY

SUBMITTER INFORMATION Livingston County Health Department
Submitting Institution

310 E. Torrance Avenue	Pontiac	IL	61764
Submitter Address (Street Number, Name of Street)	*City*	*State*	ZIP Code

Jackie Dever/Mary Jo Krall	815-844-7174	815-842-2408	jdever@lchd.us
Contact Person/Clinician's Last Name	*Telephone Number*	*FAX*	*E-mail Address*

PATIENT INFORMATION:

Patient's Last Name | First Name | Middle Name

Street Address | Apartment/Suite Number

City | State | ZIP Code

Telephone Number | Birthday (mm/dd/yyyy) | Age | Child Guardian *if under 18

Sex

Female

Yes **I have access to OSF MyChart**
*Those with access will retrieve their COVID-19 test results via OSF MyChart. Those without access to OSF MyChart will be contacted by the Livingston County Health Department. If a person tests positive for COVID-19, their local health department will reach out to them via phone to conduct a contact tracing investigation.

INSURANCE INFO

Bill Insurance Below

Bill Insurance below

Recipient ID # _____ Policy Holder First Name _____

Group/Policy # _____ Policy Holder Last Name _____

Insurance Company

_____ Policy Holder DOB _____

TEST REQUEST INFORMATION: ***For Staff Use ONLY***

_____ ____ : ____am( ) pm( ) _____
Date Collected (mm/dd/yyyy) **Time Collected** **Collectors Initials**

TEST: **COVID-19**

SOURCE/SPECIMEN TYPE (one source type per form)

✔ Nasal Swab

DIAGNOSIS/TESTING REASON

❑ Asymptomatic/Symptomatic-Exposure or suspected exposure to COVID-19 **Z20.828**
❑ Asymptomatic-No Exposure to Covid-19 **Z11.59**

❑ Patient ID # (optional)_____