Please submit specimen & this order form to:

McKenzie-Willamette
MEDICAL CENTER

1460 G Street, Springfield, Oregon 97477
Phone: 541.744.8544 Fax: 541.744.8595

COVID-19 Request Form

Laboratory Services Request Form

All fields must be completely filled or testing and resulting may be delayed.

PATIENT INFORMATION					
LAST NAME	FIRST NAME	M.I.	DOB	GENDER	
			__/__/____	❒ MALE	❒ FEMALE
Phone#	Address:				
Sample or Reference#					

DATE COLLECTED	TIME COLLECTED	COLLECTOR

INSTRUCTIONS: Specimens must be labeled with patient's name (last and first), date of birth, date and time of collection, collector's initials, and source of specimen (nasopharyngeal (NP) or oropharyngeal (OP)

PHYSICIAN INFORMATION & FAX DISTRIBUTION			
ORDERING PHYSICIAN: Barbara Hoefener	Call Results to: (*) PATIENT (*) 541-262-6470 (office)	PH: Digital clinic 541-262-6470	FAX: 833-970 0970

Instructions: Physician name (Last and First) and contact information is required. Results will be returned via fax.

Ordering Physician Signature: Barbara Hoefener

✓	TEST CODE	CPT	TEST DESCRIPTION	Transport tube
	COVID-CM	87635	COVID-19 PCR test	Viral Transport Medium, saline

✓	Must indicate Symptom
	Pre-Op
	Cough
	Shortness of Breath
	Fever
	Encounter for observation for suspected exposure to other biological agents rule out (Z03.808)
	Contact with and (suspected) exposure to other viral communicable diseases (Z20.828)
	Encounter for screening for other viral diseases (Z11.59)

Insurance information

Insurance name:	ID#	Group #	Policy Holder name