bach diagnostics
passion, science, care
401 N. Tustin Ave., Ste. 310, Tustin, CA 92705
Tel: 1(800) 544-4181 | Fax (949) 236-6646
website: www.bachdiagnostics.com
e-mail: lab@bachdiagnostics.com
CLIA Number: 05D2101629

PRACTICE INFORMATION: Name, Address, Phone Number

Laboratory Order Form

IMPORTANT: Face masks are required for your visit. Please visit the draw station located at the following address: **TruCare Health – 1234 W. Chapman Ave., Suite 101, Orange, CA 92866.** Please be ready to present your health insurance information at the time of your visit.

Patient Information (Please fill out ALL of the information in this section):

Have you been previously diagnosed with COVID-19? ☐ Yes ☐ No | If yes, when: (most recent date) _____

Did you previously take a COVID-19 test with Bach Diagnostics? ☐ Yes ☐ No

Last Name: _____ First Name: _____ Middle Initial: _____

Sex: ☐ Male ☐ Female DOB: _____ SSN: _____

Street: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

e-mail (**for results**): _____

Insurance Type: ☐ Medi-Cal ☐ Medicare ☐ PPO ☐ Other: _____

☐ No Insurance: I attest that I don't have employer-sponsored or individual health coverage, Medicare, Medicaid, and that no other payer will reimburse for COVID-19.

Clinical Symptoms & Exposure (Select all that apply):		**Diagnosis Code (for lab use):**
☐ Exposed to an individual with COVID-19	☐ Shortness of Breath	☐ Z.20.828 – Suspected/probable exposure to COVID-19
☐ Fever	☐ Headache	☐ R05 – Cough
☐ Cough	☐ Exposed	☐ R06.02 – Shortness of Breath
☐ Sore Throat	☐ Lost of taste or smell	☐ R50.9 – Fever, unspecified
		☐ Other: _____

Medical Necessity-Clinical Features and Symptoms (Select one of the following options below):

☐ **Symptomatic Patient**	☐ **High Risk Exposure**	☐ **High-Risk Essential Worker**	☐ **Asymptomatic Surveillance**
You have one or more of these **symptoms**: Fever, cough, sore throat, shortness of breath, chills, headache, loss of smell or taste, diarrhea, runny nose.	You have **no symptoms** but have had exposure to infected individual(s) with COVID-19.	You have **no symptoms** and you are an essential worker such as healthcare worker, first responder, or social service employee.	You have **no symptoms** but are scheduled for a medical procedure/surgery, or you are part of a community or regional surveillance.

Test Panel (Select the type of COVID-19 test that you would like to take today):

☐ Antibody IgG, IgM **Blood** Test – Asymptomatic	☐ PCR **Nasal Swab** Test – Symptomatic

For Lab Use Only

Antibody – Source & Type:	PCR – Source &Type:
☐ Plasma in a Mint-top tube (lithium heparin, gel or no-gel tube)	☐ Nasopharyngeal Swab
☐ Required Volume (adult): 2 mL plasma (or serum)	☐ Oropharyngeal Swab
☐ Minimum Volume (pediatric) 1 mL plasma (or serum)	☐ Bronchoalveolar Lavage (BAL) fluid (1 mL) in sterile container
	☐ Other: _____

Specimen Intake Details

Collector's Name:	Date Collected:	Time Collected:

Authorizations:

I acknowledge that the laboratory has my permission to release my results directly to the treating physician or facility. I hear by authorize my insurance benefits to be paid directly to the laboratory for services rendered and I agree to endorse any payments received from my insurer and forward them directly to the laboratory for services rendered. By signing this authorization, I allow the release of any medical information necessary to process this claim. I, the undersigned, understand that I am responsible for all co-pays and deductibles.	The ordering physician or his/her authorized representative must sign his/her name and indicate that the test is ordered. The signature constitutes a certification that, with respects to tests reimbursed by Medicare or other third-party payers, the testing is medically necessary, and the results will be used in the management of the patient.
Patient Signature: _____	Physician/Rep Signature: _____
Date: _____	Date: _____