bach diagnostics
passion, science, care
17672 Cowan Ave, Irvine CA, 92614
Tel: 1(800) 544-4181 | Fax (949) 236-6646
website: www.bachdx.com
e-mail: lab@bachdx.com
CLIA Number: 05D2101629

PRACTICE INFORMATION: Clinic Name, Address, Phone Number

Laboratory Order Form

IMPORTANT: Patients, please fill out all fields in the highlighted sections. If you fail to provide all the required information, there will be a delay in processing your sample.

PATIENT INFORMATION (ALL FIELDS REQUIRED – *PLEASE WRITE LEGIBLY*):

Last Name **First Name** **Middle Initial**

☐ **Male** ☐ **Female** **Date of Birth** **Social Security Number** **Phone Number**

Street Address **City** **State** **Zip code**

e-mail **(Please write legibly otherwise there will be a delay in receiving your results. Avoid using the same email for multiple people as it will take longer to receive results.)**

Race: ☐ African American ☐ Asian ☐ American Indian/Alaska Native ☐ Latino ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Unknown
(Mark all that apply.)

Insurance Type: ☐ Medi-Cal ☐ Medicare ☐ PPO ☐ Other (specify below) ☐ No insurance: I attest that I do NOT have employer-sponsored or individual health coverage, Medicare, Medicaid, and that no other payers will reimburse for COVID-19.

Health Network Name Member ID number Group number

CLINICAL SYMPTOMS & EXPOSURE – Select ALL symptoms that apply:

☐ Exposed to an individual with COVID-19
☐ Fever Shortness of breath
☐ Cough
☐ Sore Throat
☐ Shortness of breath
☐ Headache
☐ Lost of taste or smell
☐ NONE

DIAGNOSIS CODE (FOR LAB USE ONLY):

□ Z.20.828 – Suspected/probable exposure to COVID-19
□ R05 – Cough
□ R06.02 – Shortness of Breath
□ R50.9 – Fever, unspecified
□ Other: ____

MEDICAL NECESSITY-CLINICAL FEATURES AND SYMPTOMS – Select ONE of the following options that best describes you:

☐ **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 test(s) that you would like the laboratory to perform:

☐ **Antibody IgG, IgM Blood Test – Test for Exposure/Immunity**

☐ **COVID PCR (SARS-CoV-2) Nasal Swab Test – Test for Current Infection**
☐ Optional: Reflex to Influenza Virus Types A and B, and respiratory syncytial virus if negative for SARS-CoV-2 ***(***If you choose this option, we will also test for the common cold, if your COVID test comes back with a negative result.***)***

FOR LAB USE ONLY

Antibody – Source & Type:
□ Plasma in a Mint-top tube (lithium heparin, gel or no-gel tube)
□ Required Volume (adult): 2 mL plasma (or serum)
□ Minimum Volume (pediatric) 1 mL plasma (or serum)

PCR – Source &Type:
□ Nasopharyngeal Swab
□ Oropharyngeal Swab
□ Bronchoalveolar Lavage (BAL) fluid (1 mL) in sterile container

SPECIMEN INTAKE DETAILS – To the patient: If you performed the nasal swab test ON YOURSELF, please fill out this section:

Collector's Full Name: Date Collected: Time Collected: AM / PM (circle one)

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: _____
Date: _____

Physician/Rep Signature: _____
Date: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

REQUIRED: **Attach patient face sheet, as well as front and back copies of current insurance card(s).**