One Health Labs
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Philadelphia, PA 19107
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TEST REQUISITION FORM

Please complete this form and return to the fax number above. Highlighted areas indicate required fields.

ORDERING PHYSICIAN/LABORATORY INFORMATION

Practice/Institution Name & Address:		
Phone Number:	Fax Number:	NPI Number:
Authorized Provider's Name:		Email Address:
Provider's Signature & Date:		

PATIENT INFORMATION

Patient's Name (Last, First):	Gender: ◯ Male ◯ Female ◯ Other_____	Date of Birth (MM/DD/YYYY):	
Social Security Number:	Phone Number:	Email Address:	
Patient's Street Address:	City:	State	Zip Code:
Symptoms/Contact: ☐ Fever ☐ Cough ☐ Shortness of Breath ☐ In contact w/symptomatic person(s) in the last 14 days? ☐ In contact w/person who tested positive for COVID-19?		Is Patient Pregnant? ◯ Yes ◯ No	

SPECIMEN INFORMATION

Collection Date:	Collection Time:	Specimen Source: ☐ NP Swab ☐ Other_____
Collected By (only required if collected by OHL):		Submitting Lab Accession # (if applicable):

TEST SELECTION

Respiratory Infectious Diseases: ☐ Check to select all as a panel ☐ Influenza A Virus by RT-PCR ☐ Influenza B Virus by RT-PCR ☐ Respiratory Syncytial Virus A (RSV A) and Respiratory Syncytial Virus B (RSV B) by RT-PCR	☐ SARS-CoV-2 by RT-PCR (COVID-19)

BILLING INFORMATION

◯ Bill Physician/Practice

◯ Bill Patient (all remaining sections required if marked) ☐ Visa ☐ Mastercard ☐ AMEX ☐ Other _____	Name on Card (as written):		
Card Number:	Expiration Date:	CVV:	Billing Zip Code:
Cardholder Signature & Date:	Billing Address (if different from patient's address):		