Testing Partners Inc.

301 E MAIN ST
LEXINGTON, KY 40507

LABORATORY REQUEST FORM

Required fields are marked with *

PATIENT INFORMATION

FIRST NAME*

LAST NAME*

GENDER*
__ Male __ Female __ Undisclosed

DOB*
/ /

RACE / ETHNICITY* __ Undisclosed
__ American Indian / Alaska Native __ Asian __ White
__ Native Hawaiian / Pacific Islander __Hispanic / Latino
__ Black / African American __ Other: _____

STREET ADDRESS*

APT/UNIT

CITY*

COUNTY OF RESIDENCE*

STATE*

ZIP*

EMAIL*

CELL PHONE
(_____) _____ - _____

SSN
__ __ __ - __ __ - __ __ __ __

CLIENT INFORMATION

CLIENT NAME
Testing Partners Inc.

STREET ADDRESS
301 E Main St

STE / UNIT
Ste 700

CITY
Lexington

STATE
KY

ZIP
40507

PHONE
(____) _____ - _____

FAX
(____) _____ - _____

COLLECTION/FACILITY SITE INFORMATION

FACILITY / SITE NAME

STREET ADDRESS

APT/UNIT

CITY

STATE

ZIP

CONTACT PHONE
(_____) _____ - _____

CONTACT EMAIL

SPECIMEN INFORMATION

COLLECTOR NAME

COLLECTION DATE*
/ /

COLLECTION TIME

SPECIMEN TYPE*

SPECIMEN TRANSPORT MEDIUM*

TEST REQUESTED

SARS-CoV2 COVID-19 -- CPT Code 87635/U0004 -- Lab Code 10096

INSURANCE INFORMATION*

INSURANCE CARRIER

POLICY ID#

GROUP#

TESTING PARTNERS INC.
301 E MAIN ST, STE 700
LEXINGTON, KY 40507

INFORMED CONSENT TO SPECIMEN COLLECTION AND LAB TESTING

Please carefully read and sign the following Informed Consent:

A. I authorize Testing Partners Inc. or its subcontractor ("TPI") to conduct collection and testing for COVID-19 through a nasal swab.

B. I authorize my identifiable health information, including test results, to be disclosed to the county, state, or to any other governmental entity as may be required by law.

C. I acknowledge that a positive test result is an indication that I must follow the guidance or direction provided by my state or county health department, which may include self-isolation in an effort to avoid infecting others.

D. I understand that TPI is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

E. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent.

I voluntarily agree to this testing for COVID-19:

_____	_____	_____
(Name)	(Signature)	(Date)

The signature of a parent or authorized guardian is required for individuals under age 18:

_____	_____	_____
(Name)	(Signature)	(Date)