COVIANT™
COVID-19 ANTIBODY TEST

SEROLOGY TESTING: COVIANT™ REQUISITION
INTERPACE DIAGNOSTICS
2515 Liberty Avenue
Pittsburgh, PA 15222

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Phone: 800-495-9885/412-224-6900 **Email:labsupport@interpace.com** **Fax: 888-674-6894/412-224-6425** **www.interpace.com**

① Patient Information

Please print or adhere patient label. Must include two (2) unique identifiers.

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yy): ____/____/____

SSN/MRN: _____ Sex: ☐ M ☐ F

② Physician Information

Submitting Physician

Account #: _____

Office/Hospital: _____

Address: _____

Phone: _____

Fax: _____

Physician: _____

NPI: _____

Results Delivery: ☐ Fax ☐ Mail ☐ Interpace Portal

③ Billing Information

A patient demographic sheet must be attached for State Department of Health reporting requirements. Additional information may be requested. Interpace Diagnostics will bill the facility directly for each test ordered.

Billing Contact

Contact: _____

Phone: _____ Fax: _____

Email: _____

Staff Contact

Staff Contact: _____

Phone: _____ Fax: _____

Email: _____

Procedure Location: ☐ Outpatient ☐ Inpatient / Discharge Date: ___/___/___ ☐ Non-Hospital/Freestanding Clinic

ICD-10 Codes:

_____ _____ _____

_____ _____ _____

The diagnosis code(s) provided should always be supported by the documentation within the patient's medical record.

④ Specimen Information

Submitted Specimens(s): *Please indicate specimen type and number of vials submitted. Each vial must be labeled with two patient identifiers.*

Specimen Collection Date (mm/dd/yy): ____/____/____

# of Whole Blood (lavender) vials
1 ☐ 2 ☐ 3 ☐

# of Serum (red/gold) vials
1 ☐ 2 ☐ 3 ☐

Diagnostic Questions (Check all that apply):

- ☐ Patient had positive testing of viral COVID-19 RNA
- ☐ Patient had exposure to COVID-19 but is asymptomatic
- ☐ Patient had a COVID-19 Convalescent Plasma (CCP) transfusion
- ☐ Patient is asymptomatic and no known exposure to COVID-19

Patient has:
- ☐ Fever
- ☐ Cough
- ☐ Shortness of breath
- ☐ Other _____

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- ☐ Fever
- ☐ Cough
- ☐ Shortness of breath
- ☐ Other _____

☐ Other relevant diagnostic information

_____

_____

⑤ Test Menu

COVIANT™ Serology Testing:

IgG: COVID-19 **CPT 86769**

Order IgG Covid-19 Testing by completing, signing and dating the authorization in section 6 of this requisition.

Serology Sample Collection and Handling Guidelines

- EDTA plasma (min 2 mL, lavender) or cell-free serum (min 1 mL, poured off) are acceptable
- Lavender topped tubes are provided in the Interpace Collection kit for collection of plasma
- Red or gold topped tubes are acceptable for cell free serum prep and collection
- Samples must be shipped on cold blocks provided in kit
- Samples must be stored refrigerated (2-8 °C) until shipping
- Please use provided kit for expedited delivery to Interpace
- Kits can be requested by contacting Interpace Client Services at 800-495-9885

⑥ Authorization

I hereby certify that the request for the above test(s) for which reimbursement from the institution will be sought is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition.

MD/DO Signature: _____ **Order Date:** _____/_____/____

Print Name: _____

⑦ Patient Authorization

☐ *I hereby confirm that I have discussed the test, its purpose, benefits, risks, and limitations with my doctor. I have asked my doctor any questions and have had them answered to my satisfaction*

☐ *I hereby authorize that any residual sample may be stored and used anonymously for research development, quality assurance, clinical trials, research studies, or commercial purposes.*

If no selection is made and a signature is present, both above statements will be applied.

Patient Signature: _____ **Order Date:** _____/_____/____

Print Name: _____

Interpace Diagnostics®

INTERPACE USE ONLY: Rec'd by: _____ Date/Time Rec'd: _____