RML
REGIONAL MEDICAL LABORATORY
4142 S Mingo Rd Tulsa, OK 74146 (918) 744-2500
WWW.RMLONLINE.COM (800) 722-8077

☐ CALL
☐ FAX

☐ STAT

Note:
All tests marked with the Frequency ◎ symbol must have a signed ABN accompany the requisition.
Completed by: _____

PATIENT INFORMATION Please Provide All Information below **(Name on Requisition MUST Match Name on Specimen EXACTLY!)**

LAST NAME (Please Print Legibly)	FIRST	MIDDLE	PATIENT SS#	SEX M☐ F☐	DATE OF BIRTH [MM / DD / YYYY]

PATIENT ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

COLLECTION DATE:	TIME: ☐ A.M. ☐ P.M.	☐ Fasting ☐ Non-Fasting	PATIENT MRN.	NAME OF GUARANTOR:

FOR LAB USE ONLY
LAB ID:

RCV'D TIME/DATE:

SPECIMENS RCV'D
☐ **Un-Spun**

☐ Red/Gray(SST)
☐ Gold(SST)
☐ Red
☐ Lavender
☐ Green (PST)
☐ Dk Green
☐ Blue
☐ Gray
☐ Navy
☐ Pink
☐ Yellow ACD
☐ Blood Culture
☐ Urine
Lid Color ____
Cup ____
Jug ____
Mono V ____
☐ Occult Blood
☐ Slide
☐ Stool
☐ Swab
Color ____
☐ Aptima Swab
☐ Pour off
Spec Type ____
☐ ICT Kit
☐ Other: _____ _____

REQUESTING PHYSICIAN [Last Name, First Name]

Provider Name _____
Please Print

Provider signature: _____
The tests that are ordered within this requisition are medically necessary for the treatment of this patient.

BILLING INFORMATION (Required)

BILL: ☐ **PROVIDER/ OFFICE** ☐ **PATIENT/ INSURANCE**

Please provide a photo copy of the patient's insurance card(s)

PRIMARY INSURANCE CARRIER	2nd - INSURANCE CARRIER
POLICY/ MEMBER/ MEDICARE NUMBER	2nd - POLICY/ MEMBER/ MEDICARE NUMBER
GROUP NUMBER/ PERSONAL CODE	2nd - GROUP NUMBER/ PERSONAL CODE
POLICY HOLDER	2nd - POLICY HOLDER
EMPLOYER	2nd - EMPLOYER

CONSULTING COPY TO PHYSICIAN(s) [Last Name, First Name]
(COMPLETE MAILING ADDRESS or FAX NUMBER is REQUIRED to SEND a CONSULT REPORT)

Indicate if reason for visit is related to Hospice Care: **YES** ☐ **NO** ☐

Provide the Name of Hospice: _____

1.	2.	3.	4.	5.	6.

Link each DX code above to the test by writing the box number next to the corresponding test name. Physicians should only order tests which are medically necessary for the diagnosis or treatment of the patient. **Medicare will not pay for screening tests.**

RML ANALYZER PANELS / CUSTOM PANELS / OTHER TESTS NOT LISTED / ADDITIONAL DX DIAGNOSIS CODES 9-2019

Test Name	Test Code
SARS-CoV-2 by PCR	6907557

Novel Coronavirus (SARS-CoV-2/COVID-19)

Novel Coronavirus (SARS-CoV-2/COVID-19)

AOC - Ask On Order Entry	Response		
Is the patient pregnant?	Yes [ ]	No [ ]	Unknown [ ]
Is this the first test for COVID -19?	Yes [ ]	No [ ]	Unknown [ ]
Is the patient employed in healthcare?	Yes [ ]	No [ ]	Unknown [ ]
Group Care Resident?	Yes [ ]	No [ ]	Unknown [ ]
Symptomatic?	Yes [ ]	No [ ]	Unknown [ ]
If Symptomatic, Date of Onset	Date:		
Hospitalized?	Yes [ ]	No [ ]	Unknown [ ]
ICU?	Yes [ ]	No [ ]	Unknown [ ]

Collection Instructions:

1. Acceptable swabs have synthetic tips (NO cotton or calcium alginate) and plastic shafts (NO wooden shafts).
2. Collect a single nasopharyngeal specimen. Oropharyngeal specimens will not be rejected, but due to decreased sensitivity, are NOT preferred. Nasal (nares specimens) are NOT advised.
3. Place swab in a transport tube containing 1-3 mL VTM, UTM, M6, M4 or sterile saline; eSwabs may also be used for collection.
4. Place tightly sealed specimen within a biohazard bag, one patient specimen per bag. Swabs in media or saline should be refrigerated until picked up.

To reduce the risk of exposure and specimen rejection due to specimen leakage, please follow the instructions below depending on the type of collection kits:

1. Break or cut the swab shaft down to the size where the swab and shaft fit inside the tube well enough that the CAP will fit securely.
2. Make sure push caps are pushed down straight and tight, wrap with parafilm if available.
3. Make sure screw caps are on straight and screwed tightly.
4. All caps should be flush with the tube.

If you have any questions please call Communications @ 918-744-2500 option 2 then option 1