SACRED HEART EMERGENCY CENTER
9774 Katy Freeway Suite 500
Houston, Texas 77055
Tel # 832.358.0200 Fax # 832.358.0202

Demographic Form

Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Alt. Phone:** _____

Email: _____

I DO NOT WISH TO BE EVALUATED BY SACRED HEART EMERGENCY CENTER

_____

PRINT NAME OF DONOR **DATE**

COVID Donor Signature or Legal Guardian: _____ **Date:** _____

*****If at any time you feel you need to be seen by a physician, you are more the welcome to check in as a patient at Sacred Heart Emergency Center. No appointment needed. Open 24/7.**

_____

WITNESS **DATE**

Respiratory Health
Corona Virus Testing

CVT 1001

APCHealth
2817 Miller Ranch Rd. Ste. 317, Pearland, TX 77584
Phone: (281) 240-0974 Fax: 1-844-604-0145
CLIA # 45D2111506
Director's Name: **Dr. Yan Zou, Phd, TC(NRCC), C(ASCP).**

Clinic Name: _____
Address: _____
Phone: _____ Fax: _____

ALL THE HEADERS IN RED 1, 2 & 6 MUST BE FILLED

1 Patient Information

Last Name _____
First Name _____ MI _____
Date of Birth _____ ☐ Male ☐ Female
SSN _____ Tel _____
Address _____
City _____ State _____ Zip _____

2 Insurance

Attached Copy of Insurance Card & Demographic Sheet

Insurance Type : Medicare Medicaid Commercial Self-Pay

Policy Holder name _____
Policy # _____ DOB (MM/DD/YYYY) _____
Relationship to patient : Self Spouse Parents

5 Specimen Processor

Date: ___/___/_____ Time: __:__ AM PM
Collector's Name _____

6 Patient Signature

X _____ Date: ___/___/___

I authorize APC Health to analyze the specimen provided by me and report the results of such analysis to the ordering Physician in conformance with his/her order. (further explanation on back)

7 Authorized Provider Signature

Print Name _____
Signature _____ Date: ___/___/___

8 Physician Medical Necessity Notice

Physicians and other authorized persons are required to onlyorder medically necessary tests supported by an ICD-10 diagnosis from the patient's medical record.

3 Respiratory Panel

☐ Viral Targets	☐ Bacterial Targets
☐ Adenovirus	☐ Bordetella Pertussis
☐ Coronavirus HKU1	☐ Bordetella Parapertussis
☐ Coronavirus NI63	☐ Chlamydia Pneumoniae
☐ Coronavirus 229E	☐ Mycoplasma Pneumoniae
☐ Coronavirus Oc43	☐
☑ Coronavirus COVID-19	☐
☐ Human Metapneumovirus	☐
☐ Human Rhinovirus/Enterovirus	☐
☐ Influenza A	☐
☐ Influenza A/H1	☐
☐ Influenza A/H3	☐
☐ Influenza A/H1-2009	☐
☐ Influenza B	☐
☐ Parainfluenza virus 1	☐
☐ Parainfluenza virus 2	☐
☐ Parainfluenza virus 3	☐
☐ Parainfluenza virus 4	☐
☐ Respiratory Syncytial Virus	☐
☐	☐
☐	☐

4 Additional Comments/Testing Requests

9 Diagnosis Codes

↓ PEEL HERE ↓

Patient Name: _____ Collectors Initials: _____
Date of Collection: _____ Date of Birth: _____

CVT 1001

Please fill out this sticker area and place on sample cup.