Valley Medical Laboratory

Covid-19 Antibody Order Form

Lab Information:

Lab Name: Valley Medical Laboratory
Address: 2438 E 117th St, Burnsville, MN 55337
Phone: (612) 286-8366 **Fax:** 612-444-9000

Patient To Complete *(please complete **ALL** fields or attach Face Sheet for a valid order):*

Last Name: _____ MI: _____ First: _____

DOB: _____ Sex: _____ Patient ID #/MRN: _____

Phone: *(mobile preferred)* _____ Secondary Phone: _____

Patient Address: _____

Insurance Carrier: _____ ID #: _____ Group #: _____

Insurance Address: _____

Referring Provider To Complete *(please complete **ALL** fields for a valid order):*

Provider Name & Title: _____ NPI: _____

Clinic Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Test Profile Information		
Test(s) Ordered	Specimen Req.	Dx (ICD)
COVID-19 IgG Antibody Testing	2ml Venous Blood Draw Serum Separator Tube	Z20.828, Contact with and (suspected) exposure to other viral communicable diseases _____

Authorization – *Please Sign and Date*

_____ _____

Physician/Referral Provider Signature Order Date

Send form via FAX: 612-444-9000

or

Email: covid19@valleymedical.com