South Coast Family Medical Center
25500 Rancho Niguel Road
Suite 100
Laguna Niguel, CA 92677
Phone: (949) 643-0500 Fax: (949) 643-3748

ORDER REQUISITION FORM

Date: _____

Time: _____ AM/PM

PATIENT NAME & ADDRESS

First name: _____ Last name: _____

DOB: _____ Age: _____ Phone number: _____

DIAGNOSES (ICD)

Z20.828: Exposure to coronavirus infection
Z03.818: Observation and evaluation for suspected exposure to other biological agent

ORDERING PROVIDER

Electronically signed by:

Dr. Lauren Davis, DO
NPI 1457647901

Dr. Chris Davis, DO
NPI 1356637813

REQUESTED STUDIES

[X] COVID19 Sophia Sars2 Antigen, rapid test, CPT 87426

For internal use:
Results: [ ] positive [ ] negative

Disclaimer:
By signing below, I acknowledge that I have been exposed to COVID19 and/or have symptoms and desire to have the Quidel Sophia2 rapid antigen test as acknowledged by the FDA Emergency Use Act. I acknowledge that if I test too early (before 5 days) and my test is negative, it may be a false negative. I agree to see medical care if my symptoms are concerning. Lastly, if I test positive, I agree to quarantine myself for at least 10 days following the start of my symptoms with at least 3 days of NO symptoms.

_____ _____
Signature Date

This form is not valid without a stamp