

## Texas Mobile Testing LAB REQUEST – Community COVID-19 Testing

Attach Patient Label

Location/Submitter Public Health Region

QRF Facility:

County:

Requesting Provider Dr. John Hellerstedt, MD

Collection Date **(Required)**

Collection Time **(Required)**

Collector Name **(Required)**

Diagnosis/ (ICD-10)

	Test Description	CPT®	Collection Container
X	<b>COVID-19 Testing [LAB002110]</b>	U0002	Nasopharyngeal Swab in Universal Transport Media

Additional instructions / comments:

**LC#: 42243820**