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A b r i s h a m i

D e r m a t o p a t h o l o g y

Pathology Laboratory

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COVID-19 ANTIBODY TEST ROCHE ELECSYS IgM AND IgG MULTISTEP IMMUNOASSAY

COVID-19 ANTIBODY IgM and IgG

Directions:

Transport in serum tube (red top), 2mL or 4mL
Serum is stable at 15-25°C for 3 days
Spin 12min prior to transport for highest stability
Min. vol. is 1mL (pediatric 1mL OK)

DATE COLLECTED TIME : AM PM

Known diagnoses of COVID-19? If so, when?

Patient Name (Last)		(First, Middle)	
Patient Phone Number ()		Date of Birth	Gender M F
Patient Address		City	State Zip Code
<input type="checkbox"/> Call me with my results		Ethnicity (mandated by CA DPH)	
<input type="checkbox"/> Fax my results Fax no. ()		WH BK AS NA HL	

BILL TO:

- MEDICARE
- PPO
- CLIENT

Primary Insurance Co. Name (please attach copy of front/back of ins)	
Member/Insured Name (if other than patient) (Last) (First, Middle)	
Relationship to Insured	
Member ID #	Group #
Insurance Address	City State Zip Code

Requesting Provider	
Requesting Provider Name	
Requesting Provider NPI #	
Requesting Provider Fax No. (for reporting all results)	
Requesting Provider Signature	Date

I authorize the performance of the COVID-19 Antibody Test

Signature _____ Date _____