TREASURE COAST
Urgent Care

RAPID ANTIGEN COVID-19 TEST RESULTS

SARS-COV2 Binax Antigen Rapid Test Administered On: 12/16/2025

Patient Name: New Test
DOB: 01/04/1994

Testing Time:
RESULTS: **NEGATIVE**

CLIA # D-1052947

Provider:
Providers Signature

TREASURE COAST URGENT CARE
1050 SE MONTEREY RD. SUITE 101 STUART, FL 34994 | p. 772-419-0560 f. 772-403-2379 | www.tcurgentcare.com

New Test 01/04/1994

DoseSpotClinic

Patient Information

Patient Name:	New Test
Date of Birth:	01/04/1994
MRN:	328797
Sex:	Male
SSN:	
Employer:	
Address:	Sw Koso St Tualatin, OR 97062
Phone Number:	+18055555555
Email:	

Provider Information

Provider Name:
Email Address:

Insurance Information

Insurance Company:
Policy Number:
Policy Holder:
Insurance Group Number:
Relationship:

Order Form

12/06/2023

DoseSpotClinic
N Washington Ave
Green Brook, NJ 08812

NPI:

Phone: (860) 944-9421 Fax: (860) 995-9416

Stewart Slater Male 01/02/2000
(860) 955-9531

Scott Dr
Hillsborough, NJ 08844

Primary Insurance

Insurance Address

Subscriber Name

Insured Name

Address

Priority:

ICD10 Code

MR MUSCULOSKELETAL

- ☐ Shoulder
- ☐ Elbow ☐L ☐R
- ☐ Wrist ☐L ☐R
- ☐ Hand ☐L ☐R
- ☐ Hip ☐L ☐R
- ☐ Knee ☐L ☐R
- ☐ Lower Leg ☐L ☐R
- ☐ Ankle ☐L ☐R
- ☐ Foot ☐L ☐R
- ☐ MR Arthrography Specify joint:

MR BODY

- ☐ Abdomen ☐ Pelvis
- ☐ MRCP ☐ Liver
- ☐ Kidney

MR NEURO

- ☐ Brain
- ☐ IAC's/Orbits
- ☐ Pituitary
- ☐ Soft Tissue Neck
- ☐ Brachial Plexus ☐L ☐R
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
  - ☐ w/3D Myelogram
- ☐ Sacrum/Coccyx
- ☐ WEIGHT BEARING MRI

MR SPECIAL

- ☐ Breast
- ☐ Cardiac
- ☐ Enterography (MRE)
- ☐ Prostate
- ☐ TMJ
- ☐ Urogram
  (Abd/Pel w/wo with 3D recon)

MRA

- ☐ Brain ☐ Carotid
- ☐ Abdomen ☐ Kidney
- ☐ Runoff (Abd, Pel, Bilat legs)
- ☐ MRV Specify area of interest:

☐ MR OTHER Specify area of interest:

CT NEURO

- ☐ Brain ☐ Sinus
- ☐ Facial Bones
- ☐ IAC's/Temporal Bone
- ☐ Orbits ☐ Soft Tissue Neck
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine

CT MUSCULOSKELETAL ☐

Extremity (Specify area of interest)

- ☐ w/3D Recon.

☐ CT Arthography (Specifc Joint)

CT BODY

- ☐ Chest ☐ Abdomen ☐ Pelvis
- ☐ Urogram (Abd/Pel w/wo with 3D recon)
- ☐ Cardiac Calcium Score
- ☐ Low Dose Lung Screen

VASCULAR CT ANGIOGRAPHY

(All with IV contrast–no oral contrast)

- ☐ CTA Brain ☐ CTA Carotids
- ☐ CTA Chest (Pulmonary Embolus Protocol)
- ☐ CTA Aorta (Chest, Abd, Pel)
- ☐ CTA Coronary Arteries
- ☐ CTA Venous Structure
- ☐ CT OTHER (Specify area of interest)

_____

X-RAY/FLUOROSCOPY

- ☐ Chest ☐ Abdomen
- ☐ Pelvis ☐ Cervical Spine
- ☐ Thoracic Spine ☐ Flex
- ☐ Lumbar Spine ☐ Ext.
- ☐ Scoliosis/AP & LAT (T+L Spine)
- ☐ Pelvis Hip ☐RT &/or ☐LT
- ☐ Upper Extremity Indicate Site:
  _____ ☐RT ☐LT
- ☐ Lower Extremity Indicate Site:
  _____ ☐RT ☐LT
- ☐ Upper GI-W/Air per Rad*
- ☐ Ba Enema-W/Air per Rad*
- ☐ Esophagram*
- ☐ Small Bowl Study*
- ☐ Other

NUCLEAR MEDICINE Provide comparison films

- ☐ DaTscan
- ☐ Bone Scan Whole Body
- ☐ Bone Scan 3 Phase of:

☐ Bone Scan Limited of:

- ☐ Hepatobiliary Scan (HIDA)
  ☐ With EF ☐ W/O EF
- ☐ Thyroid Scan & Uptake*
- ☐ Liver/Spleen Scan
- ☐ Parathyroid Scan with SPECT
- ☐ Muga Resting
- ☐ Gastric Emptying Scan* Single Phase Only
- ☐ Renogram* ☐Lasix ☐No Lasix
- ☐ Renogram* With Captopril
- ☐ Lung Scan ☐Vent/LPerf ☐Quantilation
- ☐ Other _____

WOMEN'S IMAGING

- ☐ 3D Mammogram - Screening
- ☐ 3D Mammogram - Diagnostic
  w/ CAD and Breast US if questionable mammo ☐L ☐R ☐B
- ☐ Breast US - Screening ☐L ☐R ☐B
- ☐ Breast US - Diagnostic ☐L ☐R ☐B
- ☐ DEXAscan ☐L ☐R ☐B
- ☐ Stereotactic Biopsy ☐L ☐R ☐B
- ☐ Needle Localization ☐L ☐R ☐B
- ☐ US biopsy ☐L ☐R ☐B
- ☐ Cyst Aspiration ☐L ☐R ☐B
- ☐ MR Biopsy ☐L ☐R ☐B

PET

- ☐ PET/Skull Base to Thigh*
- ☐ PET / Whole Body*
- ☐ PET/Brain Amyvid Alzheimers
- ☐ PET/Brain* ☐ PET/Bone Scan

ULTRASOUND

- ☐ Abdomen
- ☐ Pelvis w/ Transvaginal
- ☐ Aorta
- ☐ Retroperitoneum
- ☐ Scrotum
- ☐ Thyroid

VASCULAR ULTRASOUND

- ☐ Arterial ☐ Venous
  - ☐ Upper Ext.
  - ☐ Lower Ext.
    ☐L ☐R ☐BILAT
- ☐ ABI
- ☐ Insufficiency
- ☐ Carotid
- ☐ Renal Doppler

☐ US OTHER (Specify area of interest)

_____

Electronically signed by

Application Form for Registration of Clinical Establishments

I.ESTABLISHMENT DETAILS

1.**Name of the establishment**: _____

2.**Address**: _____
Village/Town:_____ Block:_____
District: _____State: _____ Pin code_____
Tel No (with STD code):_____Mobile: _____Fax : _____
Email ID : _____Website (if any): _____

3.**Month and Year of starting**: _____

(From 4 to 11 mark all whichever are applicable)

4. **Location:**
Rural Urban Metro
Notified / inaccessible areas (including Hilly / tribal areas)

5. **Ownership of Services**

Government/Public Sector
Central government State government Local government (Municipality, Zilla parishad, etc)
Public Sector Undertaking Other ministries and departments (Railways, Police, etc.)
Employee State Insurance Corporation Autonomous organization under Government

Non-Government / Private Sector
Individual Proprietorship Partnership Registered companies (registered under central/provincial/state Act) Society/trust (Registered under central/provincial/state Act)

6. **Name of the owner of Clinical Establishment:** _____
Address: _____
Village/Town:_____Block:_____District: _____State: _____ Pin code_____
Tel No (with STD code):_____Mobile: _____Fax : _____
Email ID: _____

7. **Name, Designation and Qualification of person in-charge of the clinical establishment**: _____
Qualification(s): _____
Registration Number: _____
Name of Central/State Council (with which registered): _____
Tel No (with STD code):_____Fax: _____Mobile: _____E-mail ID: _____ __

8. Systems of Medicine offered: (please tick whichever is applicable)
Allopathy Ayurveda Unani Siddha Homoeopathy Yoga Naturopathy Sowa-Rigpa

9. Type of establishment :(please tick whichever is applicable)

(I).**Clinic (Outpatient)**

- Single practitioner
  (Consultation services only/with diagnostic services/with short stay facility)

- Poly clinic
  (Consultation services only/with diagnostic services/with short stay facility)
- Dispensary
- Health Checkup Centre

(II). Day Care facility

Medical Surgical Medical SPA Wellness centers (where qualified medical professionals are available to supervise the services).

(III). Hospitals including Nursing Home (outpatient and inpatient):

- Hospital Level 1 a
- Hospital Level 1 b
- Hospital Level 2
- Hospital Level 3 (Non teaching)
- Hospital Level 4 (Teaching)

(IV). Dental Clinics and Dental Hospital:

a. Dental clinics

i. Single practitioner
ii. Poly Clinics (dental)

b. Dental Hospitals (specialties as listed in the IDC Act.)

i. Oral and maxillofacial surgery
ii. Oral medicine and radiology
iii. Orthodontics
iv. Conservative dentistry and Endodontics
v. Periodontics
vi. Pedodontics and preventive dentistry
vii. Oral pathology and Microbiology
viii. Prosthodontics and crown bridge
ix. Public health dentistry

(V).Diagnostic Centre

A. Medical Diagnostic Laboratories:

Pathology Biochemistry Microbiology
Molecular Biology and Genetic Labs Virology

B. Diagnostic Imaging centers

i. Radiology

- General radiology
- Interventional radiology

ii. Electromagnetic imaging

- Magnetic Resonance Imaging (MRI),
- Positron Emission Tomography (PET) Scan

iii. **Ultrasound**

C. Miscellaneous

- Electro Cardio Graphy(ECG)
- Tread Mill Test
- Electro Encephalo Graphy(EEG)
- Mammography
- Echocardiography
- Electro MyoGraphy (EMG)
- Electrophysiological studies

D. **Collection centers**

For the clinical labs and diagnostic centres shall function under registered clinical establishment

Yes/No

if Yes, then No of Collection Centre: ☐

(VI). Allied Health professions:

- Audiology
- Behavioral health (counseling, marriage and family therapy etc)
- Exercise physiology
- Nuclear medicine technology
- Medical Laboratory Scientist
- Dietetics
- Occupational therapy
- Optometry
- Orthoptics
- Orthotics and prosthetics
- Osteopathy
- Paramedic
- Podiatry
- Health Psychology/ Clinical Psychology
- Physiotherapy
- Radiation therapy
- Radiography / Medical imaging
- Respiratory Therapy
- Sonography
- Speech pathology

(VII) AYUSH

Ayurveda

Ausadh Chikitsa Shalya Chikitsa Shodhan Chikitsa Rasayana Pathya Vyavastha

Yoga

Ashtang Yoga

Unani

Matab Jarahat Ilaj-bit-Tadbeer Hifzan-e-Sehat

Siddha

Maruthuvam Sirappu Maruthuvam Varmam Thokknam & Yoga

Homoeopathy

General Homoeopathy

Naturopathy
External Therapies with natural modalities Internal Therapies

II.TYPES OF SERVICE

- **TYPE**

General Practice Services
Single Specialty Services
Multi Specialty Services (including Palliative care Centre, Trauma Centre, Maternity Home - applicable for hospitals only)
Super Specialty Services

- **SPECIALITY SPECIFIC**

Medical Specialties – for which candidates must possess recognized PG degree (MD/Diploma/DNB or its equivalent degree)

i. Anesthesiology
ii. Aviation Medicine
iii. Community Medicine
iv. Dermatology, Venerology and Leprosy
v. Family Medicine
vi. General Medicine
vii. Geriatrics
viii. ImmunoHaematology and Blood Transfusion
ix. Nuclear Medicine
x. Paediatrics
xi. Physical Medicine Rehabilitation
xii. Psychiatry
xiii. Radio-diagnosis
xiv. Radio-therapy
xv. Rheumatology
xvi. Sports Medicine
xvii. Tropical Medicine
xviii. Tuberculosis & Respiratory Medicine or Pulmonary Medicine

Surgical specialties - for which candidates must possess, recognized PG degree (MS/Diploma/DNB or its equivalent degree)

i. Otorhinolaryngology
ii. General Surgery
iii. Ophthalmology
iv. Orthopedics
v. Obstetrics & Gynecology

Medical Super specialties –
i. Cardiology
ii. Clinical Hematology including Stem Cell Therapy
iii. Clinical Pharmacology

iv. Endocrinology
v. Immunology
vi. Medical Gastroenterology
vii. Medical Genetics
viii. Medical Oncology
ix. Neonatology
x. Nephrology
xi. Neurology
xii. Neuro-radiology

Surgical Super-specialities-

i. Cardiovascular thoracic Surgery)
ii. Urology
iii. Neuro-Surgery
iv. Paediatrics Surgery.
v. Plastic & Reconstructive Surgery
vi. Surgical Gastroenterology
vii. Surgical Oncology
viii. Endocrine Surgery
ix. Gynecological Oncology
x. Vascular Surgery

III INFRASTRUCTURE DETAILS

10. **Area of the establishment** (in sqft):
a) Total Area: _____b) Constructed area: _____

11. **Out Patient Department:**
11.1 Total no. of OPD Clinics: _____

11.2 Specialty-wise distribution of OPD Clinic

S.No.	Specialty

12. **In Patient Department:**
12.1. Total number of beds: _____
12.2. Specialty-wise distribution of beds, please specify:

S.No.	Specialty	Beds

13. **Biomedical waste Management**
13.1 **Method of treatment and /or disposal of Bio-medical waste**
☐ Through Common Facility ☐ Onsite Facility
☐ Any other (please specify): _____

13.2.**Whether authorization from Pollution Control Board/Pollution Control Committee obtained**?

☐ Yes ☐ No ☐ Applied For ☐Not Applicable

IV HUMAN RESOURCES

14. **Total number of Staff (as on date of application):**

No. of permanent staff:_____ No. of temporary staff: _____

Please furnish the following details:-

Category of staff	**Name**	**Qualification**	**Registration No**	**Nature of service Temporary/ Permanent**
Doctors				
Nursing staff				
Para-medical staff				
Pharmacists				
Administrative staff				
Others, please specify				

Separate annexure may be attached.

Support Staff

Category	Total no.	Remark

15. **Payment options for Registration Fees:**

☐ Online payment☐ Demand Draft Bank Challan

Amount (in Rs):_____

Details: _____

Receipt No._____

I,. .....on behalf of myself and the company/ society/association/body hereby declare that the statements above are correct and true to the best of my knowledge and I shall abide by all the provisions made under the Clinical Establishment (Registration and Regulation) Act 2010.

I undertake that I shall inform the DistrictRegistering Authority of any changes in the particulars given above.

I shall comply with the minimum standards prescribed under Clinical Establishment Act for the services provided by us and also all other conditions of registration as stipulated under the aforesaid Act and Rule there-under.

Place: Signature of the Authorized Signatory

Date: Office Seal

Lab Report Format Template

Title	
Introductory Paragraph	
State Problem / Purpose	
Hypothesis	
Materials:	
Procedure	
Data / Results / Observations	
Analysis / Calculations	
Conclusion	
Works Cited	
Additional Notes	


MEDICAL BILL RECEIPT

DRLOGY PATHOLOGY LAB

Accurate | Caring | Instant

0123456789 | 0912345678

drlogypathlab@drlogy.com

105 -108, SMART VISION COMPLEX, HEALTHCARE ROAD, OPPOSITE HEALTHCARE COMPLEX. MUMBAI - 689578

www.drlogy.com

Yash M. Patel
Age : 21 Years
Sex : Male
PID : 555

Sample Collected At:
125, Shivam Bungalow, S G Road,
Mumbai

Ref. By: **Dr. Hiren Shah**

Registered on: 02:31 PM 02 Dec, 2X
Collected on: 03:11 PM 02 Dec, 2X
Reported on: 04:35 PM 02 Dec, 2X

RANDOM BLOOD SUGAR (RBS)

Investigation	Result		Reference Value	Unit
GLUCOSE, RANDOM, PLASMA Hexokinase	245.00	Very High	70.00 - 140.00	mg/dL

Interpretation

The reference values for a "Normal" Random Glucose test in an average adult are 70–140 mg/dL (4.4–7.8 mmol/l), between 140-200 mg/dL (7.8–11.1 mmol/l) is considered pre-diabetes, and > 200 mg/dL is considered diabetes according to ADA guidelines (you should visit your doctor or a clinic for additional tests)

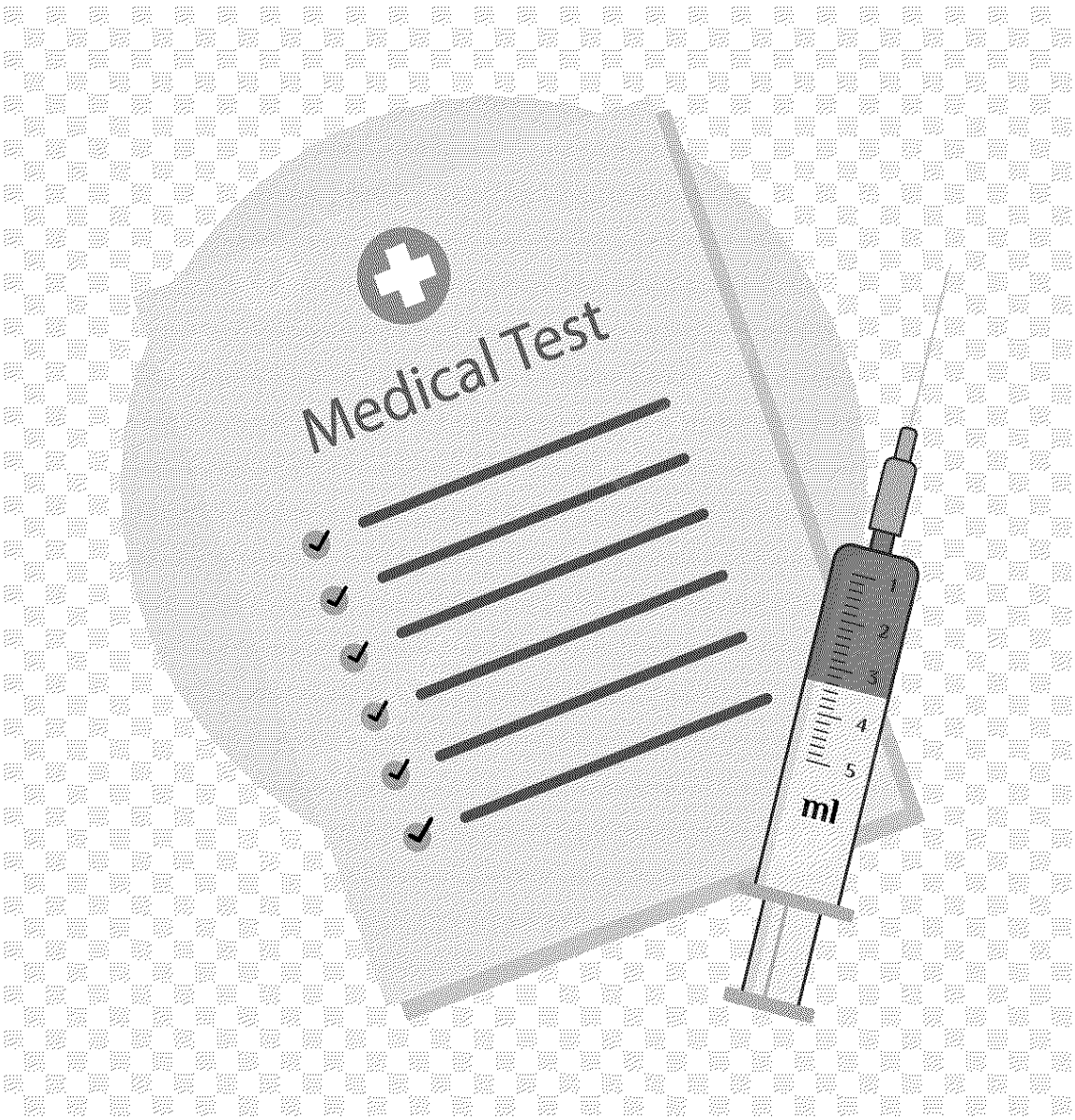
Thanks for Reference

****End of Report****

Medical Lab Technician
(DMLT, BMLT)

Dr. Payal Shah
(MD, Pathologist)

Dr. Vimal Shah
(MD, Pathologist)


Medical Test
1
2
3
4
5
ml

New Tags

These tags can be used as values for pdf documents forms. The system will replace these tags with the values described below.

328797	Medical Record Number - patient id from the database
	Primary Insurance Company Name
	Secondary Insurance Company Name
	Primary Insurance Member ID
Abrasion	Chief Complaint (Can be multiple)
10:07 AM	Appointment Time
31	Patient Age
Male	Patient Sex
	Workers' Comp Accident Date
	Workers' Comp Claim Number
	Workers' Comp Insurance Name
	Visit Insurance Name - visit insurance company name.
	Visit Insurance ID Number - insurance number on the primary insurance tied to visit
	Primary Care Provider Name. Primary care physician on the patient.
New	Patient First Name
Test	Patient Last Name
Sw Koso St	Patient Street Address Line 1
	Patient Street Address Line 2
Tualatin	Patient City
OR	Patient State
97062	Patient ZIP Code
(805) 555-5555	Patient Phone Number. Formatted.

	Social Security Number
DoseSpotClinic	Clinic Name
123 N Main St	Clinic Street Address Line 1
str 2	Clinic Street Address Line 2
Brooklyn	Clinic City
MI	Clinic State
49230	Clinic ZIP Code
(956) 825-0925	Clinic Phone Number. Formatted
(332) 241-0212	Clinic Fax Number
	Provider First Name
	Provider Last Name
	Secondary Insurance Member ID
	Workers' Comp State
	Workers' Comp Employer Name. If not then Occ Med Employer Name

Lab Results. Test name and result. Each name-result pairt on the new line.

procedureOrderResults

Legacy Tags

These tags can be used as values for pdf documents forms. The system will replace these tags with the values described below.

New Test	Patient Full Name
(805) 555-5555	Patient Phone Number
01/04/1994	Patient Date of Birth formatted to MM/dd/yyyy
	Patient Email
	Patient Street Address. Each address line on the new line.
Sw Koso St	
Tualatin, OR 97062	Patient City, State, ZIP formatted to "Patient City, State ZIP"
12/16/2025	Date of issue formatted to MM/dd/yyyy
	Provider Full Name
	Visit diagnosis codes
New Test Sw Koso St Tualatin, OR 97062 (805) 555-5555 01/04/1994	Patient Demographics
New Test Male 01/04/1994	Patient Information: patient full name + patient set + patiend date of birth.
01/04/1994	Patient Date of Birth, formatted to MM/dd/yyyy
12/16/2025	Order Date
05:07 AM	Order Time
(956) 825-0925	Clinic Phone Number, formatted.
(332) 241-0212	Clinic Fax Number, formatted
Sw Koso St Tualatin, OR 97062	Patient Full Address

Insurance Name - primary patient insurance company name.

Insurance Address - primary patient insurance full address.

Subscriber's Name - first and last name on patient primary insurance.

Insured Name - patient full name. Populates only if patient has primary insurance.

Insured Address - patient full address. Populates only if patient has primary insurance.

Insurance Information - primary insurance company name then primary insurance full address on the new line. Populates only if patient has primary insurance.

Diagnosis Code - comma separated list of Icd10Cm codes on visit diagnosis.

Diagnosis Name - comma separated list of diagnosis code names on visit

Clinic Full Address

123 N Main St str 2 Brooklyn, MI 49230

Provider Full Name - visit provider full name.

NPI Number - visit provider npi number

Primary Care Provider Name - fulle name of primary care physician on the patient.

New Tags

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Clinic Full Address

123 N Main St str 2 Brooklyn, MI 49230

Provider Full Name - visit provider full name.

NPI Number - visit provider npi number

Primary Care Provider Name - fulle name of primary care physician on the patient.