Predicine

This Long Form is For New Student/Staff One-Time Registration Only

LABORATORY INFECTIOUS DISEASE REQUISITION

Please check corresponding circle for each category:

◯ New ◯ Student ◯ Faculty ◯ Friends/Family ◯ Patient

[PLACE BARCODE]

School Name & District:

RAPID TEST RESULT: [-Neg. / +Pos.]

Vaccinated? ☐ Yes ☐ No

Patient Information *REQUIRED

*Name (First, Middle, Last) | *Date of Birth | *Cell Phone

*ADDRESS | *CITY, STATE, ZIP | *Email

*ETHNICITY ☐ Hispanic ☐ Non-Hispanic/Latino ☐ Unknown ☐ Decline

*RACE: ☐ White ☐ Black/Afr. Amer. ☐ Amer. Ind/Alaskan ☐ Asian/Pacific Islander ☐ Other ☐ Unknown ☐ Decline

*Gender: ☐ Female ☐ Male ☐ Non Binary

Insured Individuals *REQUIRED *If Uninsured, Please See Below

*Insurance Company Name | *Insurance/Subscriber #: | Relationship to Subscriber: ☐ Self ☐ Child ☐ Parent ☐ Spouse

*Subscriber's Name | *Subscribers Date of Birth | HMO or PPO Plan: ☐ HMO ☐ PPO

☐ I Attest And Affirm That I Do Not Have Insurance

☐ I Attest and Affirm that I do not have Documentation

If you do not have insurance please provide Social Security or Driver's License Number or Passport Number → _____

I, The Parent/Guardian have read the entirety of this document front and back. *REQUIRED

By signing I acknowledge, and confirm that the information is true and correct.

Patient/Parent/Guardian Full Name Print:

*Patient/Parent/Guardian Signature: Date:

SIGNS & SYMPTOMS

☐ NONE	☐ Chills	☐ Sneezing	☐ Loss of Taste/Smell	☐ Muscle/Body Ache	☐ Confusion
☐ Cardiovascular	☐ Sore Throat	☐ Nausea/Vomiting	☐ Headache Trouble	☐ Fatigue(Tiredness)	
☐ Fever(>100.4°F)	☐ Pale/Discolored Skin	☐ Coughing	☐ Breathing	☐ Inability to sleep/wake	

Testing Information(For Predicine Staff Only)

Specimen Source (SS): ☐ Anterior Nasal(AN) ☐ Saliva ☐ Oral Pharyngeal Swab(OP)	Date Collected: Time Collected:
Diagnosis/ICD:	Temp Storage: Room Temp ☑

Predicine, Inc., 3555 Arden Road, Hayward, CA 94545
Office: (650) 300-2188

Lab Director: John J. Iocco, M.D.
CLIA: 05D2148483

Authorization, Consent, Release of Liability, and Hold-Harmless Agreement

I understand the purpose of this self-health screening questionnaire is intended to help myself make decisions about seeking the appropriate medical care. By answering the questionnaire, I understand that this is only an informational tool and does not give medical advice, diagnosis, or treatment, this can be done only by a license healthcare professional.
I Authorized the release of medical information Protected Health Information (PHI) to share my screening questionnaire responses with a professional health care provider

I, Hereby authorize and want Predicine to receive payment from this bill from my health insurance. With this assignment of benefit, I know I am responsible for the full payment, co-payment, coinsurance or deductibles. If the insurance pays me for the services, I will send the checks to Predicine. I authorize the release of medical information necessary to process the claim and act as my power of attorney for the request of appeal and documents.

In signing this form, I give permission for my child/self to be tested for COVID- 19, I also understand that this consent will be valid for my child until my child's 18th birthday. I understand the risks and benefits of getting the COVID-19 test and provide consent to PREDICINE to release the COVID-19 Test Results to the authorized COVID-19 Representative.

In consideration for receiving the COVID-19 test, I hereby RELEASE, WAIVE, DISCHARGE, HOLD HARMLESS AND COVENANT NOT TO SUE PREDICINE, officers, employees and volunteers (hereinafter referred to as RELEASEES) from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or related to any loss, damage, injury, or illness including, without limitation, any loss, damage, injury, or illness caused by or related to receiving the COVID-19 test, that may be sustained by me or other family members or any person who may contract COVID-19 from the undersigned or such participating individuals or from any property belonging to Predicine. WHETHER CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, in any way connected to or arising out of the receiving the COVID-19 test.

I UNDERSTAND THAT PREDICINE WILL NOT BE RESPONSIBLE FOR ANY MEDICAL COSTS OR DAMAGES ASSOCIATED WITH ANY INJURY OR ILLNESS IN ANY WAY RESULTING FROM THE COVID-19 TEST.

If you think you have a medical emergency, call your doctor or 911 immediately or go to the emergency room.

The COVID-19 Screening Questionnaire is based upon current guidance for exposure risk management from the Center for Disease Control and Public Health Agencies. The screening questionnaire attempts to identify individuals who may have had a medium to high risk of exposure to the COVID-19 Virus. All patients are therefore urged to follow the guidance for at cdc.gov/coronavirus and local country department of health.

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