Predicine

LABORATORY INFECTIOUS DISEASE REQUISITION

Please check corresponding circle for each category:

○ New ○ Existing ○ Student ○ Faculty
○ Friends/Family ○ Other

[PLACE BARCODE]

PATIENT INFORMATION		CLINICAL/FACILITY INFORMATION	
*NAME: (LAST, FIRST, MIDDLE)		*TESTING FACILITY NAME & ADDRESS:	
*DOB	*SSN or ID#		
*PHONE	*GENDER ☐ FEMALE ☐ MALE	*PHYSICIAN NAME John J. Iocco, M.D.	*DATE COLLECTED:
*ADDRESS		*NPI: 1902840283	*TIME COLLECTED: ☐ AM ☐ PM
*CITY, STATE, ZIP		PHONE:	
*EMAIL:		SPECIMEN SOURCE (SS): ☐ Anterior Nasal (AN) ☐ Oral Pharyngeal Swab (OP) ☐ Saliva	
*ETHNICITY ☐ Hispanic ☐ Unknown ☐ Non-Hispanic/Latino ☐ Decline	SPORT		
*RACE: ☐ White ☐ Black/Afr Amer ☐ Amer Ind/Alaskan ☐ Asian/Pacific Islander ☐ Other ☐ Unknown ☐ Decline		TEMP STORAGE: ☒ Room Temp	
*BILL TO *(Please check one)*	☐ Insurance ☐ Test Location ☐ Facility ☐ Medicare ☐ Patient	You should be aware that Medicare generally does not cover routine screening and will only pay for tests that are covered the program and are reasonable & necessary to treat or diagnosis the patient. If this is a routine screening an Advance Beneficiary Notice (ABN) needs to be sign by the patient on the back of this requisition.	
INSURANCE INFO	*Please attach a copy of front & back of Insurance card or face sheet*	**TEST MENU**	
INSURANCE COMPANY		☐ COVID-19 SARS-COV-2 MOLECULAR PCR TEST ☐ COVID-19 SARS-COV-2 ANTIBODY (IGM/IGG)	
POLICY #			
GROUP #			
SUBSCRIBER NAME			
RELATIONSHIP	☐ SELF ☐ CHILD ☐ PARENT ☐ SPOUSE	***OTHER TESTS/PANELS:***	
*DIAGNOSIS/ICD			

I certify that the test(s) requested on this order form are medically necessary for this patient, and that the full and appropriate diagnosis codes are indicated based on the patient's medical records. When ordering tests for which is Medicare reimbursement will be sought, physician should only order tests which are medically necessary for diagnosis or treatment of the patient.

*PHYSICIAN SIGNATURE		*DATE

I, hereby authorize and want Predicine, Inc. 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, Inc.. I authorize the release of medical information necessary to process the claim and act as my power of attorney for request of appeal and documents.

*PATIENT/PARENT/ GUARDIAN SIGNATURE		*DATE

*REQUIRED INFORMATION

PATIENT CURRENTLY RESIDES IN

___Private Resident ___Hotel ___Homeless ___Detention Facility ___ Nursing Home/Long Term Healthcare ___Residential Care/Assisted Living ___ School/University Dorm ___ Military Base Shelter ___Other:

OCCUPATION	____Healthcare Worker ___ Teacher ___ First Responder (Fire, Police, EMT) ____Other: ____Other (Essential):

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

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

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CLINICAL INFORMATION		
DATE OF ONSET SYMPTOMS	HOSPITALIZED ___ YES ___NO	DATE OF ADMISSION
RECENT SURGERIES THAT REQUIRED HOSPITAL STAY? ___ Yes ___No	Please specify?	

SIGNS & SYMPTOMS				
___ None	___ Muscle Aches	___ Sore Throat	___ Subjective Fever	___ Abdominal Pain
___ Cough	___ Diarrhea	___ Chills	___ Runny Nose	___ Shortness of Breath
__ Fever (>100.4°F)	___ Vomiting	___ Nausea	___ Headache	___Other, Specify:

PRE-EXISTING MEDICAL CONDITIONS				
___ None	___Unknown	___ Diabetes	___ Hypertension	___ Pregnant
___ Cardiovascular	___ Chronic pulmonary disease	___ Asthma	___ Chronic Renal Disease	___ Chronic Liver Disease
___ Anemia	___ Neurologic Disability	___ HIV	___ Cancer/Tumor	___ Organ Transplant
___Receiving Dialysis	___ Immunocompromised	___ Neurologic Disability	___ Other, Specify:	

DO YOU SMOKE?	___ Yes ___ No	LAST PHYSICAL	
MEDICATIONS	___ Yes ___No	Specify:	

RISK FACTORS

CLOSE CONTACT WITH A LABORATORY CONFIRMED COVID-19 PATIENT		____ Yes ___ No	Date
International Travel/Cruise	____ Yes ___ No	City/Region/Province/State/Country	
Dates of Travel	To:	From: Arrived in U.S.	
No Symptoms	____ Yes ___ No		
Do you have other health concerns?	____ Yes ___ No	Please Specify:	

I have read, understood, acknowledge, and confirm that the information is true and correct on the Screening Questionnaire. I understand that 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.

Patient/Parent/Guardian Signature:_____ Date:_____

If you think you have a medical emergency, call your doctor or 911immediately 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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