Predicine

LABORATORY INFECTIOUS DISEASE REQUISITION

Please check corresponding circle for each category:

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

[PLACE BARCODE]

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

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

No Insurance Individuals

ATTESTATION: I attest and affirm that I currently do not have insurance.* ☐

*Please Provide Driver's License # or State ID# or SSN *

*Patient Signature: | *Date:*

SIGNS & SYMPTOMS *Required

☐ NONE ☐ Chills ☐ Sneezing ☐ Loss of Taste/Smell ☐ Muscle/Body Ache ☐ Confusion

☐ Cardiovascular ☐ Sore Throat ☐ Nausea/Vomiting ☐ Headache ☐ Fatigue(Tiredness)

☐ Fever(>100.4°F) ☐ Pale/Discolored Skin ☐ Coughing ☐ Trouble Breathing ☐ Inability to sleep/wake

CLINICAL/FACILITY INFORMATION

Testing Facility Name & Address:

Temp Storage: Room Temp ☑

Date Collected:

Time Collected:

Diagnosis/ICD:

Specimen Source (SS): ☐ Anterior Nasal(AN) ☐ Saliva ☐ Oral Pharyngeal Swab(OP)

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

*Patient/Parent/Guardian Signature: | *Date:*

Authorization

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 the request of appeal and documents.

Patient/Parent/Guardian Signature: | Date:

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

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

Authorization Cont. (Patient or Patient's Guardian Currently Resides in)			
☐ Private Resident	☐ Homeless	☐ Detention Facility	☐ Nursing Home/Long Term Healthcare
☐ School/University Dorm	☐ Military Base Shelter	☐ Residential Care/Assisted Living	☐ Other:
OCCUPATION:	☐ Healthcare Worker	☐ Teacher	☐ Other(Essential):
	☐ Other:	☐ First Responder (Fire, Police, EMT)	

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.