EXPRESS GENE MOLECULAR DIAGNOSTICS LABORATORY

COVID-19 TEST REQUISITION FORM

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Patient Information

First Name: | Last Name:

DOB | SEX: M ☐ F ☐

Street Address:

City/State/Zip:

Phone: | MRN:

Email:

Ethnicity: ☐ European (Finnish) ☐ African ☐ East Asian ☐ Ashkenazi Jewish ☐ Near/Middle Eastern ☐ Other ☐ European (Non-Finnish)

Ordering Physician Information

First Name: | Last Name:

Institution/Practice Name: | NPI#:

Street Address:

City/State/Zip: | Phone:

Email: | Fax:

Additional Copy of Results (If applicable)

Name:

Email: | Fax:

Confirmation of Informed Consent and Medical Necessity for COVID-19 Testing

My signature below certifies that I am a licensed medical professional or his/her representative authorized to order genetic testing. My signature further acknowledges the patient has been supplied information regarding COVID-19 testing and has been informed about the purpose, limitations and possible risks. The patient has been given the opportunity to ask questions about this consent. The patient has given consent for COVID-19 testing to be performed and the signed consent form is on file.

I confirm that this testing is medically necessary for the specified patient, and that these results will be used in the medical management and treatment decisions for this patient.

I confirm that the patient has been informed and hereby authorizes (i) Express Gene Molecular Diagnostics to release information concerning their testing to CDC, Public Heath Authorities, their insurer in order to obtain reimbursement for the testing services; (ii) Express Gene Molecular Diagnostics to be paid directly by the insurer for services rendered; and/or if applicable (iii) Express Gene Molecular Diagnostics or its affiliates to be the patient's designated representative for the purpose of appealing any denial of insurance benefits. I confirm the patient fully understands they are legally responsible for sending Express Gene Molecular Diagnostics any and all of the money that they receive directly from their insurance company in payment for this testing.

Medical Professional Signature _____ Date _____

Tests Ordered

☐ 2019-nCoV Real-Time RT-PCR Diagnostic Panel

This laboratory developed test is intendeIt is important to emphasize the use of this test as part of a comprehensive patient evaluation, including clinical and epidemiological criteria for the diagnosis of COVID-19, as recommended by the CDC guidelines. This test DOES NOT identify Coronaviruses other than SARS-CoV-2 or other respiratory viruses or bacteria. It is recommended that Patients Under Investigation (PUI) for COVID-19 are communicated to the local County Public Health Department.

Sample Collection Type: ☐ Nasal Swab ☐ Oral/Buccal Swab ☐ Sputum ☐ Pharyngeal Swab ☐ Bronchoalveolar lavage (BAL)

Date of Collection: (MM/DD/YYYY) _____

PATIENT DIRECT BILL. **Insurance billing is not currently available in our laboratory. Full Payment is responsibility of patient.**

Amount: $ 198.00

Card Type: ☐ VISA ☐ Mastercard ☐ Discover ☐ AMEX

Card # | CVC# | EXP Date:

Name as it appears on card:

I authorize Express Gene Molecular Diagnostics to charge my credit card the amount listed above.

Signature: _____ Date: _____