Respiratory Molecular Diagnostic Requisition ☐ *(Not to be billed Client Bill to insurance)*

*All tests on this form may require a signed ABN**

Employer Information

Company Name_____

Employer Name _____

Employer Phone _____

X DR. Anthony Kearney/1851340756
Physician name/NPI

Patient Information

Patient Name_____
(First Name, Last Name)

Address_____

City _____ State _____ Zip _____

Cell # _____

q You agree to be contacted via automated system with telephone calls or text messages regarding your lab order. You may opt out of receiving calls or texts by texting STOP or calling (855) 436-8979.

SS# _____

Date of Birth ____ /____ /_____Gender: ☐ Male ☐ Female

Drug Allergy(ies): ☐NKA_____

Collection Information

Collection Date _____ / _____ /_____

Billing Information (Please attach copies of both cards, front and back)

PRIMARY

☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ☐ **Self Pay** ☐**Ordering Physician** ☐ **Billing Information Attached**

InsuranceCarrier_____Policy/ID#_____Group#_____

SECONDARY

☐ **Medicare** ☐ **Medicaid** ☐ **Insurance** ☐ **Self Pay** ☐**Ordering Physician** (no ins. info needed)

ICD-10 CODE(S) _____

(See list on reverse side for references.)

☐ Respiratory Pathogen Panel plus COVID-19

☐ Respiratory Pathogen Panel

Viral Targets

Influenza A	Rhinovirus/Enterovirus	Adenovirus
Influenza A H1	Parainfluenza virus 1	Coronavirus HKU1
Influenza A H3	Parainfluenza virus 2	Coronavirus NL63
Influenza B	Parainfluenza virus 3	Coronavirus 229E
Respiratory Syncytial Virus A	Parainfluenza virus 4	Coronavirus OC43
Respiratory Syncytial Virus B	Human Metapneumovirus	Human Bocavirus

Bacterial Targets

Chlamydophila pneumoniae	Mycoplasma pneumoniae	Legionella pneumoniae

X **COVID - 19 Only**

☐ Group A Strep

☐ Bordetella Pertussis/Parapertussis

☐ Flu A/B and RSV

SPECIMEN LABEL INSTRUCTIONS:

1. Complete required information above (highlighted areas and test request).
2. Remove labels and place one bar coded label VERTICALLY on each specimen vial (not on the lid).
3. Please discard any unused labels. The unique barcode identifies the patient with this requisition.

Please ensure the patient name, test request and specimen source is indicated so that both the label and registration match. Two patient identifiers are required on each specimen submitted.

ADVANCE BENEFICIARY NOTICE INSTRUCTIONS

All tests on this form are subject to coverage limitations by Medicare and may require that an Advance Beneficiary Notice (ABN) be signed by the patient prior to obtaining the specimen. When ordered tests are likely to be denied by Medicare, please complete a separate ABN with the patient's signature and date, submitting it with this requisition.

NOTE: For the convenience of the ordering physicians, the below ICD-10 codes are listed. Physicians are not required to use these codes but should report the diagnostic codes that best describes the reason for performing the test.

RPP DIAGNOSIS ICD-10 CODES

MARK (✓)	ICD-10	DESCRIPTION
	Z20.828	Exposure to COVID19
	B97.29	Other Viral Pneumonia
	J20.8	Acute Bronchitis
	B97.29	Acute bronchitis due to other specified organisms
	NOS – J22	Lower Respiratory Infection
	B97.29	Unspecified acute lower respiratory infection
	J80, B97.29	Acute Respiratory Distress Syndrome (ARDS)
	J12.89	Viral Pneumonia
	R05	Cough
	R06.02	Shortness of Breath
	R50.9	Fever

INFORMED CONSENT TO SPECIMEN COLLECTION AND LAB TESTING

Please carefully read and sign the following Informed Consent:

A. I authorize RCA Laboratory Services, LLC d/b/a GENETWORx or its subcontractor ("GENETWORx") to conduct collection and testing for COVID-19 through a nasal swab.

B. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

C. I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.

D. I understand that GENETWORx is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

E. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time.

I voluntarily agree to this testing for COVID-19:

_____	_____	_____
(Name)	(Signature)	(Date)

The signature of a parent or authorized guardian is required for individuals under age 18:

_____	_____	_____
(Name)	(Signature)	(Date)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize RCA Laboratory Services, LLC ("GENETWORx") to release my COVID-19 test results to Keeneland Association Inc ("Provider")

INFORMATION TO BE RELEASED

I understand that the information released will include any of the following Protected Health Information, as available:

- COVID-19 test results, including to detect the presence of COVID-19.

CONDITIONS OF AUTHORIZATION

I understand that GENETWORx is providing this COVID-19 screening at Keeneland Association Inc request and for purposes of disclosing the results to ("Provider") and, therefore, if I refuse to sign this authorization, then I will not be eligible to receive the COVID-19 screening.

I have read the above and authorize the release of my Protected Health Information to Keeneland Assocation, Inc:

_____	_____	_____
(Name)	(Signature)	(Date)