BIO GENETISYS, INC.

471 W. Lambert Rd #104
Brea, CA 92821
P: (714) 257-9344
F: (714) 257-9348

CLIA: 05D2105680

Ordering Physican:______________________________

Address:______________________________

City/State/Zip:______________________________

Phone:______________________________

Fax:______________________________

Respiratory Test Requisition/ COVID-19

PATIENT INFORMATION

Last Name ______________________________

First Name______________________________MI________

Specimen Collection Date:______________Time:____________

DOB (MM/DD/YYYY)____________________Gender : Male Female

Address______________________________

City______________________________

State__________________ZIP__________________

Preferred Phone: _(   )______________

☐ **Complete Respiratory Panel**

- •Adenovirus
- •Coronavirus 229E
- •Coronavirus HKU1
- •Coronavirus OC43
- •Coronavirus Covid-19
- •Influenza A
- •Influenza A/ H1
- •Influenza A/ H3
- •Influenza A/H1N1/pdm09
- •Influenza B
- •Human Metapneumovirus A & B
- •Human Rhinovirus/ Enterovirus
- •Parainfluenza 1 (PIV1, PIV2, PIV3, PIV4)
- •Respiratory Syncytial Virus A & B

Bacteria:

- •Bordetella pertussis
- •Chlamydophila pneumoniae
- •Mycoplasma pneumoniae

DIAGNOSIS ICD-10 CODES

( ) G93.3 Postviral fatigue syndrome
( ) J01.90 Acute sinusitis, unspecified
( ) J02.9 Acute pharyngitis, unspecified
( ) J00 Acute nasopharyngitis (common cold)
( ) J06.9 Acute upper respiratory infection, unspecified
( ) J11.0 Influenza due to unidentified influenza virus with pneumonia
( ) J12.9 Viral pneumonia, unspecified
( ) J45.901 Unspecified asthma with acute) exacerbation
( ) J20.9 Acute bronchitis, unspecified
( ) J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
( ) R05 Cough
( ) R50.9 Fever, unspecified
( ) R53.1 Weakness
( ) R53.83 Other Fatigue
( ) U07.1 (2019 nCoV acute respiratory disease)

INSURANCE (Provide copy of front & back of card)

INSURANCE: MEDICARE ☐ OTHER ☐

Medicare #______________________________

Insurance Company______________________________

Policy /Plan Name______________________________

Group #__________________Member ID__________________

Policyholder's Name:______________________________

Relationship to Patient? ☐ Self ☐ Spouse ☐ Parent

Policyholder DOB__________________SSN__________________

PH______________________________

PATIENT SYMPTOMS

- ☐ Coughing
- ☐ Nasal Discharge
- ☐ Fever
- ☐ Wheezing
- ☐ Headache
- ☐ Myalgia
- ☐ Body Aches
- ☐ Fatigue
- ☐ Nasal Congestion
- ☐ Sneezing
- ☐ Watery Eyes
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Low Blood Oxygen Level
- ☐ Loss of Consciousness
- ☐ Congestion
- ☐ Scratchy or itchy Throat

PATIENT AUTHORIZATION (or guardian)

The information I have provided on this form is accurate. I authorize Bio Genetisys Inc. to release the results of this test to my treating physician or facility.I hereby authorize my insurance or other payment to Bio Genetisys Inc. for services I receive. I am aware that Bio Genetisys Inc. may be an out of network provider with my insurer. I am aware that I am responsible for all co-pays and deductibles not covered by insurance or other payers.

Patient Signature__________________________Date:__________

Printed Name of Patient ______________________________

PHYSICIAN AUTHORIZATION

I authorize testing for this patient is medically necessary for the diagnosis/ treatment As part of my antibiotic stewardship policy, I find it medically necessary to rapidly determine and differentiate a viral and/or bacterial infection in order to treat with or without appropriate antibiotics. Having the most accurate and timely data available to me directly guides my treatment and patient management.

Medical Professional Signature______________________________

Date:______________________________
(MD/DO, Clinical Nurse, Specialist, Nurse Practitioner, Physician Assistant)