BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
GRAND BLVD. RECEIVING DOCK
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

COVID-19 (SARS-COV-2) AND FLU (INFLUENZA A/B) RT-PCR TEST REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Address | City | State | Zip | Phone

Email | Hospital / Medical Record #

Biological Sex:
◯ Female ◯ Male
◯ Gender identity (if different from above): _____

_____ - _____ - _____ Social Security Number

Patient discharged from the hospital/facility: ◯ Yes ◯ No

RACE

◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ Hispanic or Latino
◯ Native Hawaiian or Other Pacific Islander
◯ White
◯ Other: _____

ETHNICITY

◯ Non-Hispanic
◯ Hispanic

ORDERING PROVIDER

Provider Last Name | Provider First Name | Institution Name

NPI (USA) | MINC (Canada) | Provider Title | Provider Phone | Provider Fax

Provider Address | City | State | Zip | Country

Email

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

◯ Pay with Sample ◯ Bill to Patient

◯ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

◯ **INSURANCE**

ICD-10 Valid Code: _____ Referral / Prior Auth. _____

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. Name of Ordering Physician 3. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM/DD/YYYY) | Patient's Relationship to Insured | Phone of Insured

Address of Insured | City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone | Primary Member Policy # | Primary Member Group #

Baylor Genetics will be releasing medical information concerning the test to health departments, as required by regulations, and the insurance company of record upon request. The patient or insured will be responsible for any co-pay, co-insurance, and unmet deductible that the insurance company dictates, as well as any outstanding balance not paid for by the insurance company for reasons including, but not limited to, non-covered and unauthorized services. Please note that Medicare does not cover routine screening tests.

ORDERING PROVIDER STATEMENT OF MEDICAL NECESSITY (REQUIRED)

By signing below, I, the Ordering Provider, attest that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test. I confirm that testing is medically necessary and that test results may impact medical management for the patient.

Ordering Provider Printed Name | Ordering Provider Signature | Date (MM / DD / YYYY)

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Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Biological Sex

COVID-19 TESTS

TEST CODE	TEST NAME
☐ 1299	COVID-19 (SARS-CoV-2) RT-PCR Test
☐ 1296	COVID-19 (SARS-CoV-2) and Flu (Influenza A/B) RT-PCR Test

SAMPLE

SAMPLE TYPE

- ◯ Nasal Swab in VTM/UTM
- ◯ Nasopharyngeal Swab in VTM/UTM
- ◯ Oropharyngeal Swab in VTM/UTM
- ◯ Nasal Swab in PBS/NS
- ◯ Nasopharyngeal Swab in PBS/NS
- ◯ Oropharyngeal Swab in PBS/NS
- ◯ Other: _____

SAMPLE TYPE KEY:

NS Normal Saline
PBS Phosphate Buffered Saline
UTM Universal Transport Media
VTM Viral Transport Media

DATE OF COLLECTION (MM/DD/YYYY) ___ / ___ / _____

TIME OF COLLECTION ___ : ___ ◯ AM ◯ PM

SAMPLE STORAGE

Refrigerated (2C to 8C) in VTM or UTM, specimen should be received within 72 hours of collection. If VTM or UTM are not available, then PBS or NS may be used. If specimen cannot be delivered within 72 hours of collection, the specimen should be frozen and shipped at -70C or colder.

SHIPPING ADDRESS

Label all specimen tubes with two identifiers (e.g. first and last name, date of birth).

Baylor Genetics
2450 Holcombe, Grand Blvd. – Receiving Dock
Houston, Texas 77021-2024

COVID-19 CLINICAL INFORMATION (REQUIRED FOR STATE REPORTING)

Is this the patient's first test for COVID-19?
◯ Yes ◯ No ◯ Unknown

Is the patient employed in healthcare?
◯ Yes ◯ No ◯ Unknown

Has the patient been hospitalized?
◯ Yes ◯ No ◯ Unknown

Has the patient been admitted to the ICU?
◯ Yes ◯ No ◯ Unknown

Is the patient a resident in a congregate care setting (e.g. nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treament facilities, group homes, board and care homes, homeless shelter, foster care, or other setting)?
◯ Yes ◯ No ◯ Unknown

Is the patient pregnant?
◯ Yes ◯ No ◯ Unknown

Is the patient symptomatic as defined by the CDC?
◯ Yes ◯ No ◯ Unknown

DATE OF ONSET OF SYMPTOMS
(MM/DD/YYYY) if applicable ___ / ___ / _____

ICD10 DIAGNOSIS CODE(S):

Pneumonia (COVID-19)
- ☐ J12.89 Pneumonia, Other viral pneumonia

Acute Bronchitis (COVID-19)
- ☐ J20.8 Acute Bronchitis, Unspecified

Acute Respiratory Distress Syndrome (COVID-19)
- ☐ J80 Acute Respiratory Distress Syndrome

Lower Respiratory Infection (COVID-19)
- ☐ J22 Acute lower respiratory infection, Unspecified
- ☐ J98.8 Other specified disorders

Signs and Symptoms without Definitive Diagnosis of COVID-19
- ☐ Z03.818 Suspected exposure to COVID-19
- ☐ Z20.828 Known Exposure to COVID-19
- ☐ Z11.59 Asymptomatic Screening with Negative Result or No Exposure

Additional Diagnosis Codes:
- ☐ R05 Cough
- ☐ R06.02 Shortness of Breath
- ☐ R50.9 Fever, Unspecified
- ☐ Other: _____

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			/ /	

CLINICAL INFORMATION - CONTINUED (REQUIRED FOR STATE REPORTING)

PRE-EXISTING CONDITIONS

- ☐ Asthma
- ☐ Diabetes
- ☐ Concurrent Infection
- ☐ Heart Conditions
- ☐ Immunocompromised
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Obesity
- ☐ Currently Pregnant
- ☐ Cancer Type: _____
- ☐ Other: _____

INDICATIONS FOR COVID-19 TESTING

- ☐ Asymptomatic
- ☐ Contact Tracing
- ☐ Repeat Testing for Known Positive
- ☐ Screening
- ☐ Surveillance
- ☐ Symptomatic
- ☐ Other: _____