GeneStreet Laboratories

Douglas H. Posey, MD., Laboratory Director / CLIA 45D2176552
11455 Fallbrook Drive, Suite 102, Houston, TX 77065
T 832-478-9955 F 713-903-7916
genestreet.com

CORONAVIRUS DISEASE (COVID-19) VIRUS TESTING

1. PATIENT INFORMATION (REQUIRED)

Please attach a copy of patient demographic sheet

First Name_____ Last Name_____
DOB (mm/dd/yyyy) _____ ☐ Male ☐ Female Age_____
Address_____
City_____ State_____ Zip Code _____
Phone _____ Email_____

2. PATIENT PAYMENT OPTIONS

☐ **INSURANCE: Please attach a copy of front and back of insurance card**

☐ **SELF-PAY:** Gene Street Laboratories will contact patient to obtain payment

☐ **CLIENT BILL OR INSTITUTION BILL**

3. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_____ Last Name_____
Medical Credentials_____ NPI#_____
Facility Name_____
Address_____
City_____ State_____ Zip_____
Name of Office Contact _____
Telephone: _____

4. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_____ **Collected By**_____

Specimen Type ☐ NASOPHARYNGEAL ☐ OROPHARYNGEAL ☐ SALIVA ☐ BLOOD

5. TEST REQUESTED

☐ **COVID-19-PCR**
SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV 2)
Molecular Testing by PCR
Spike glycoprotein (S protein), Nucleocapsid Protein (N-Protein), ORF1ab
Specimen type: nasopharyngeal/oropharyngeal swab, saliva

☐ **COVID-19-NAB**
SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV 2)
Neutralizing Antibody Test (NAB)
Semi-Quantitative Antibody Test
Specimen type: 1 SST tube of blood

☐ **COVID-19-HEALTH**
SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV 2)
Covid Health Panel
BNP, CBC w/diff, CMP, CRP-hs, D-Dimer, Ferritin, HBgA1c, Homocysteine, LDH, Troponin 1-hs, ANA
Specimen type: 1 SST, 2 LAV, 1 LIGHT BLUE

7. ICD10 CODES

☐ **Pneumonia (COVID-19) J12.89 Pneumonia, Other Viral Pneumonia**	☐ **R05 Cough**
	☐ **R06.02 Shortness of Breath**
	☐ **R50.9 Fever, Unspecified**
☐ **Lower Respiratory Infection (COVID-19) J22: Acute Lower Respiratory Infection, Unspecified**	☐ **J01.90 Acute Sinusitis, Unspecified**
	☐ **J02.9 Acute Pharyngitis, Unspecified**
☐ **Acute Bronchitis (COVID-19) J20.8 Acute Bronchitis, Unspecified**	☐ **J06.9 Acute Upper Respiratory Infection, Unspecified**
	☐ **J18.9 Pneumonia, Unspecified Organism**
☐ **Bronchitis (COVID-19) J40 Bronchitis, Unspecified**	☐ **J20.9 Acute Bronchitis, Unspecified**
☐ **B97.29 Pneumonia, Other Coronavirus**	☐ **J32.9 Chronic Sinusitis, Unspecified**
☐ **Z03.818 Suspected Exposure to COVID-19**	☐ **Z20.828 Known Exposure to COVID-19**

8. PATIENT INFORMED CONSENT

I have read the informed consent and I give permission to GeneStreet to perform laboratory testing as described. I understand and agree that my leftover specimen and clinical information may be used, without information directly identifying me, for research, education, and other business purposes of GeneStreet (each a "secondary use" and together "secondary uses"). I understand that this may involve GeneStreet sharing my leftover specimen and clinical information with other third parties. My leftover specimen and clinical information will be assigned a unique code before any secondary uses. My name or other personal identifying information will not be used in or linked to my specimen and clinical information when they are shared with third parties unless I explicitly authorize that disclosure. I understand that GeneStreet, itself or through its contractors on its behalf, may contact me at a later date regarding my interest in participating in other research activities, including contributing additional clinical information or specimens for use in such activities and/or authorizing the use of my identifiable information for secondary uses. More information is available at www.genestreet.com/policies/privacy-policy. This specimen was provided voluntarily for analysis and I authorize Gene Street Laboratories to process, bill and provide results. I authorize that payment(s) be made on my behalf to Gene Street for any services provided to me by Gene Street. I understand that genetic testing not performed by this laboratory will be forwarded to another accredited reference laboratory.

Patient Signature: _____ Date: _____

9. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

I attest that the patient has received and read the GeneStreet Informed Consent document, or has had it read to him or her, and 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 and a signed copy of this consent is available on file. Any GeneStreet Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent. **STATEMENT OF MEDICAL NECESSITY**: By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Ordering Physician Signature _____ Date _____