Global Brain Center

521 W. Southlake BLVD. Suite 150
Southlake, TX 76092

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RAPID COVID-19 TEST REQUISITION FORM

PATIENT INFORMATION

Patient First Name	Patient Last Name	Biological Sex ☐ F ☐ M

Date of Birth (MM/DD/YYYY)	Phone Number / Email

Address	City	State	Zip

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish(Ashkenazi) ☐ Portuguese ☐ Other

Have you experienced any of the following symptoms in the past 14 days ? Circle all that apply.

Chills Headaches Body Aches Sore Throat Loss of taste or smell Unusual Fatigue Nausea/Vomiting Dizziness
Congestion Runny Nose Trouble Breathing Diarrhea Shortness of Breath Fever Cough Other:______________

Have you been to any of the following locations in the past 14 days? Circle all that apply

Gas Stations Grocery Stores Church/Congregation Facilities Schools Work Place Medical Fascilities Concerts Sporting Events
Any place with 5 or more people

Have you been around someone who tested positive in the past 14 days? Yes No Not Sure

PATIENT INSURANCE INFORMATION - Attach patient demographics and copy of insurance card

☐ Insurance ☐ Self-Pay ☐ Client Bill ☐ Uninsured Plan

Primary Insurance	Gov't Issued ID #	Primary Insurance ID#	Primary Insurance Group
Name of Person Insured	Insured Date of Birth	Social Security Number	

SPECIMEN INFORMATION*

☐ **Respiratory** Nasopharynx Swab. Time and Date Collected __________________ Collector _______________________________

TESTS

☐ **RAPID Coronavirus Disease (COVID-19) Virus Testing** **RESULT** ☐**Invalid** ☐**Negative** ☐**Positive**
☐ **COVID-19 RT-PCR** **RESULT** ☐**Invalid** ☐**Negative** ☐**Positive**

☐ Z20.82 ☐ U07.1 Other:__________ ____________ ___________

PROVIDER INFORMATION

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. Empiric treatment and management leads to inappropriate and unnecessary antibiotic use (50% according to the CDC) and delayed diagnosis which can lead to severe consequences. Standard antibody/antigen detection is only available to detect few pathogens and comes with a high false negative rate, relatively lower sensitivity (60-70%) and specificity (80-90%). In addition, standard antibody/antigen detection requires the infection to be present for days allowing the body to make ample antibodies in order to detect. Qualitative Nucleic Acid Amplification Testing (NAAT) is far superior with sensitivities and specificities > 98% and available to detect many pathogens. In addition, NAAT has built in controls to determine if an adequate patient sample was collected and processed, therefore greatly reducing false negative results. NAAT also includes controls to easily determine a contaminated sample, therefore reducing false positive results. If the results are positive, that will be reported to Department of Health as required. I am sending one swab for both COVID-19 and RPP testing. If the repeat is necessary, a new swab will be collected from the patient.

Authorizing Provider Name: **Syed Jamal MD**	Authorizing Provider NPI# **1437157419**
Authorizing Provider Signature	Date

PATIENT CONSENT AUTHORIZATION

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to Global Brain Center, its assigned affiliates and authorized representatives for laboratory services furnished to me by Global Brain Center. I irrevocably designate, authorize and appoint Global Brain Center or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to Global Brain Center immediately upon receipt. I hereby authorize Global Brain Center, its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to Global Brain Center, in compliance with federal and state laws. I authorize the Global Brain Center, its assigned affiliates and their authorized representatives to release my personal health information, including test results, to my health plan administrator, my employer, and my authorized representative for the purpose of procuring payment to Global Brain Center, and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I am aware that if my result is positive Global Brain Center will report it to Depr of Health as required.

FOR UNINSURED PATIENTS: If you want Global Brain Center to bill the CARES ACT Provider Relief Fund for uninsured patients you MUST provide the following information. I have verified and attest to the best of my knowledge that this patient does not have coverage through an individual, employer-sponsored plan, Federal Employee Health Benefits Program, federal health program, Medicare or Medicaid and no other payer will reimburse for COVID-19 antibody testing at the time the test was ordered.

STOP **Patient Signature** ____

Signature of Patient or Patient Representative / Relationship to Patient Date:______________________________