

COVID-19 LABORATORY TEST REQUISITION AND ATTESTATION

Telephone #: 781-453-3044 option 3 | Facsimile #: 781-449-1281
[BID-NeedhamTesting@bidneedham.org](mailto: BID-NeedhamTesting@bidneedham.org)

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|---|---------------------------|---------------------------------|------|
| PATIENT INFORMATION | | | |
| Print Patient Last Name: | Print Patient First Name: | Date of Birth: | Sex: |
| Mailing Address: | | | |
| Phone # (s): | Race: | Is patient Hispanic/Latino? Y/N | |
| Name of Medical Insurance: | Insurance Policy #: | | |
| TEST : <input type="checkbox"/> COVID-19 | ICD CODE: | | |
| TYPE OF PATIENT: | | | |
| <input type="checkbox"/> Pre-op/Pre-procedure Date of procedure: _____ <input type="checkbox"/> Essential worker <input type="checkbox"/> Symptomatic outpatient <input type="checkbox"/> Asymptomatic outpatient with close contact of confirmed COVID19 <input type="checkbox"/> Travel <input type="checkbox"/> Other (please indicate): _____ | | | |
| PROVIDER INFORMATION: | | | |
| Ordering Provider Name | Telephone #: | Fax #: | |
| ORDERING PROVIDER REQUEST FOR COVID-19 LABORATORY TEST AND ATTESTATION(S) OF VERBAL CONSENT OBTAINED IN LIEU OF PATIENT SIGNATURE: | | | |
| I understand to minimize the infection control risks related to sharing pens and clipboards during the COVID-19 outbreak Beth Israel Deaconess-Needham is temporarily suspending certain patient signature requirements. | | | |
| I am requesting a COVID-19 test and have provided verbal explanation of the risks and benefits of this testing to this patient or legal representative and documented the conversation and the patient's consent with specificity in the medical record and other required forms of documentation. I am authorized to obtain verbal consent. | | | |
| X _____ / / : _____ O a.m. O p.m. Signature Circle: Physician / N.P. / P.A. Print Name Date Time (24 hour) | | | |
| COMPLETE IF PATIENT IS AN UNEMANCIPATED MINOR OR IS OTHERWISE UNABLE TO CONSENT: | | | |
| Authorized Representative for Unemancipated Minor (under age 18 years): Parent, Legal Guardian, Foster Parent with DSS Authorization or DSS. | | | |
| X _____ / / : _____ O a.m. O p.m. Print Name of Authorized Representative Date Time (24 hour) | | | |
| COMPLETE IF TRANSLATOR / INTERPRETER PARTICIPATED in OBTAINING VERBAL CONSENT: | | | |
| X _____ _____ Print First Name and Last Name of Translator Print Name of Department or Agency of Translator | | | |

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