COVID-19 LABORATORY TEST REQUISITION AND ATTESTATION

Telephone #: 781-453-3044 option 3 | Facsimile #: 781-449-1281
BID-NeedhamTesting@bidneedham.org

Beth Israel Lahey Health
Beth Israel Deaconess Needham

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 : ☐ COVID-19	ICD CODE:

TYPE OF PATIENT:

☐ **Pre-op/Pre-procedure** **Date of procedure:** _____

☐ **Essential worker**

☐ **Symptomatic outpatient**

☐ **Asymptomatic outpatient with close contact of confirmed COVID19**

☐ **Travel**

☐ **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