# Infectious Disease **Test Requisition**

FIRMALAB BIO-DIAGNOSTICS

## PATIENT INFORMATION

LAST NAME | FIRST NAME

DATE OF BIRTH (MM/DD/YYYY) | SEX ASSIGNED AT BIRTH ◯ Male ◯ Female ◯ Unknown

ADDRESS

CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PHONE | EMAIL

## ORDERING PROVIDER

INSTITUTION/PRACTICE NAME | INSTITUTION PHONE

PROVIDER LAST NAME | PROVIDER FIRST NAME

NPI # | PROVIDER ADDRESS

CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PROVIDER PHONE/FAX/EMAIL | FAX REPORT TO

## PATIENT ALLERGIES

☐ Penicillins ☐ Sulfonamides ☐ Tetracyclines ☐ Colistin
☐ Macrolides ☐ Cephalosporins ☐ Carbapanems ☐ Flouroquinolones

**Other** _____

Symptomatic as defined by CDC? ☐ YES ☐ NO ☐ UNKNOWN

## RACE/ ETHNICITY

☐ AI - American Indian or American Native
☐ A - Asian
☐ B - Black or African American
☐ PI - Native Hawaiian or Pacific Islander
☐ H - Hispanic
☐ NH - Non-Hispanic
☐ W - White ☐ O - Other ☐ U - Unknown

## TEST ORDERS

SAMPLE TYPE: ☐ Urine ☐ Blood

COLLECTION DATE (MM/DD/YYYY)

### ☐ UTI (Urinary Tract Infection)

**BACTERIA TARGETS:**
Acinetobacter baumannii
Citrobacter freundii
Enterobacter aerogenes
Enterococcus faecalis
Enterococcus faecium
Escherichia coli
Klebsiella oxytoca
Klebsiella pneumoniae
Morganella morganii
Proteus mirabilis
Proteus vulgaris Providencia Stuartii Pseudomonas aeruginosa Staphylococcus aureus Staphylococcus saprophyticus Streptococcus agalactiae Uncultured Megasphaera 1 Ureaplasma urealyticum

**FUNGI TARGETS:**
Candida species: C.albicans, C.glabrata, C. tropicalis

### ☐ ABR (Anti-biotic Resistance) Reflex

**ANTI-BIOTIC RESISTANCE PANEL:**
Carbapenems
Cephalosporins
Glycopeptides
Nitrofurans
Macrolides
Tetracyclines
Methicillin
Fosfamycin
Quinolone and Fluoroquinolones
Sulfonamides
Trimethoprim
Aminoglycosides
Extended Spectrum Beta-Lactamases

### ICD-10 CODES

☐ N39.0 UTI, site not specified
☐ R30.0 Dysuria
☐ O23.40-Unspec. infection in urinary tract in pregnancy, unspecified trimester
☐ Z11.3-Encounter for screening for infections w/ a predominately sexual mode of transmission
☐ R82.90 Unspec abnormal findings in urine
☐ OTHER _____
☐ OTHER _____
☐ OTHER _____

## BILLING INFORMATION

☐ **OPTION 1:** Insurance Billing

PRIMARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

SECONDARY INSURANCE ID | INSURANCE NAME | STATE | GROUP | INSURANCE PHONE #

INSURANCE PLAN | NAME OF INSURED | RELATION TO PATIENT | DATE OF BIRTH (MM/DD/YYYY)

☐ **OPTION 2:** Institutional **OR** ☐ **OPTION 3:** Self Pay

INSTITUTION/PAYOR FIRST & LAST NAME NAME | ATTENTION TO

ADDRESS | CITY | STATE/PROVINCE | POSTAL CODE | COUNTRY

PHONE | FAX | EMAIL

**Patient Consent:**
I am voluntarily seeking laboratory service and hereby consent to provide a sample as requested. I have the right to refuse testing, but I understand this may impact my treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand 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 understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded to the laboratory immediately.

Patient Signature: _____ Date: _____

**Physician Certification:**
This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test. The patient has been given the opportunity to ask questions and/or seek further counsel. The patient has voluntarily decided to have the test performed by Firma Lab Diagnostics Lab. As the medical provider, I am responsible for documenting applicable ICD-10 diagnosis codes.

Provider Signature: _____ Date: _____

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