

Receiving Date:  
Receiving Time:

**ACCOUNT INFORMATION**

<b>Client:</b>	<b>Site:</b>	<b>Ordering Provider:</b>	
<b>Site Contact:</b>	<b>Email:</b>	<b>Phone Number:</b>	<b>NPI:</b>

**PATIENT DEMOGRAPHICS**

<b>Collection Date:</b> / /	<b>Collection Time:</b>	<b>AM/PM:</b> <input type="checkbox"/> AM <input type="checkbox"/> PM	
<b>Last Name:</b>	<b>First Name:</b>	<b>Phone Number:</b>	
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip Codes:</b> <b>State County:</b>
<b>Date of Birth:</b> / /	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Undefined	
<b>Race:</b> <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Mixed Race <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Hawaiian/Pacific Island <input type="checkbox"/> Asian <input type="checkbox"/> Other/Unknown			
<b>Medication allergy:</b>			

(ABR\*) - Antibiotic Resistance Genes (AST\*) - Antibiotic Sensitivity Test (RSV) - Respiratory Syncytial Virus (Flu)- Influenza

- GASTROINTESTINAL PCR PANEL  CULTURE WITH AST\*

**Sample Type:**

- Rectal Swab (Eswab Kit)  Stool Sample (Stool Collection Kit)

EIA TEST (STOOL ONLY) :  FECAL OCCULT BLOOD  FECAL ELASTASE  CALPROTECTIN  HELICOBACTER PYLORI (LIAISON XL)

**CPT Codess:**

- G0328QW: Screen for colon cancer  83520: Immunoassay, infectious agent antigen; quantitative, not otherwise specified  83993: Calprotectin, fecal  
 82274QW: Diagnostic screening (patient with signs/symptoms of possible occult bleeding)

<input type="checkbox"/> ADENOVIRUS F40/41	<input type="checkbox"/> CAMPYLOBACTER JEJUNI	<input type="checkbox"/> ENTAMOEBA HISTOLYTICA	<input type="checkbox"/> NOROVIRUS GI	<input type="checkbox"/> STEC / EHEC
<input type="checkbox"/> AEROMONAS HYDROPHILA	<input type="checkbox"/> CAMPYLOBACTER POOL	<input type="checkbox"/> ENTEROBIOUS VERMICULARIS	<input type="checkbox"/> NOROVIRUS GII	<input type="checkbox"/> STRONGYLOIDES GENUS
<input type="checkbox"/> ANCYLOSTOMA GENUS	<input type="checkbox"/> CAMPYLOBACTER UPSALIENSIS	<input type="checkbox"/> ENTEROCYTOZON	<input type="checkbox"/> NOROVIRUS POOL	<input type="checkbox"/> STRONGYLOIDES STERCORALIS
<input type="checkbox"/> ASCARIS GENUS	<input type="checkbox"/> CLOSTRIDIOIDES DIFFICILE A	<input type="checkbox"/> ENTEROVIRUS	<input type="checkbox"/> PARECHOVIRUS	<input type="checkbox"/> TRICHURIS TRICHURIA
<input type="checkbox"/> ASTROVIRUS	<input type="checkbox"/> CLOSTRIDIOIDES DIFFICILE B	<input type="checkbox"/> EPEC	<input type="checkbox"/> PLESIOMONAS SHIGELLOIDES	<input type="checkbox"/> VIBRIO CHOLERAEE
<input type="checkbox"/> BLASTOCYSTIS HOMINIS	<input type="checkbox"/> CRYPTOSPORIDIUM	<input type="checkbox"/> ETEC	<input type="checkbox"/> ROTAVIRUS A	<input type="checkbox"/> VIBRIO PARAHAEOMOLYTICUS
<input type="checkbox"/> CANDIDA ALBICANS	<input type="checkbox"/> CYCLOSPORA CAYETANENSIS	<input type="checkbox"/> GIARDIA LAMBLIA	<input type="checkbox"/> ROTAVIRUS B	<input type="checkbox"/> VIBRIO POOL
<input type="checkbox"/> CANDIDA GLABRATA	<input type="checkbox"/> DIENTAMOEBA FRAGILIS	<input type="checkbox"/> HELICOBACTER PYLORI	<input type="checkbox"/> ROTAVIRUS C	<input type="checkbox"/> VIBRIO VULNIFICUS
<input type="checkbox"/> CANDIDA KRUSEI	<input type="checkbox"/> E. COLI O157	<input type="checkbox"/> HYMENOLEPIS GENUS	<input type="checkbox"/> SALMONELLA	<input type="checkbox"/> YERSINIA ENTEROCOLLITICA
<input type="checkbox"/> CANDIDA PARAPSILOSIS	<input type="checkbox"/> EAEC	<input type="checkbox"/> HYPERVIRULENT C. DIFFICILE O27	<input type="checkbox"/> SAPOVIRUS (I,II,IV)	<input type="checkbox"/> ANTIBIOTIC RESISTANCE GENES*
<input type="checkbox"/> CANDIDA TROPICALIS	<input type="checkbox"/> EIEC	<input type="checkbox"/> LISTERIA MONOCYTOGENES	<input type="checkbox"/> SAPOVIRUS G.V (V)	
<input type="checkbox"/> CAMPYLOBACTER COLI	<input type="checkbox"/> EIEC SHIGELLA	<input type="checkbox"/> NECATOR AMERICANUS	<input type="checkbox"/> SHIGELLA	

**ICD 10 Codes:**

**ANTIBIOTIC RESITANCE GENES\***

- |                                      |  |                                      |
|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> CARBAPENEMS | <input type="checkbox"/> QUINOLONE                 | <input type="checkbox"/> VANCOMYCIN  |
| <input type="checkbox"/> ESBL        | <input type="checkbox"/> SULFONAMIDE/ TRIMETHOPRIM | <input type="checkbox"/> AMPC        |
| <input type="checkbox"/> FOSFOMYCIN  | <input type="checkbox"/> TETRACYCLINE              | <input type="checkbox"/> METHICILLIN |
| <input type="checkbox"/> MACROLIDE   |  |                                      |

**BILLING INFORMATION**

<b>Insurance Company:</b>	<b>Group Number:</b>	<b>Policy Number:</b>	<input type="checkbox"/> <b>Self-Pay</b>
<b>Name of Insured:</b>	<b>Relationship to Insured:</b>	<b>DOB of Insured:</b> / /	<input type="checkbox"/> <b>Client Direct (Facility Pay)</b>

**AUTHORIZING SIGNATURES**

**Patient Request:** I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

<b>Print Patient Name:</b>	<b>Print Signature:</b>	<b>Date:</b>
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**Physician Certification:** I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

<b>Provider Authorizing Name:</b>	<b>Provider Authorizing Signature:</b>	<b>Date:</b>
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