CORE BIO LABS
Precise • Comprehensive • Reliable

RESPRITORY TEST REQUISITION

INTERNAL USE ONLY

Receiving Date:
Receiving Time:

ACCOUNT INFORMATION

Client:	Site:	Ordering Provider:	
Site Contact:	Email:	Phone Number:	NPI:

PATIENT DEMOGRAPHICS

Collection Date: / /	Collection Time:	AM/PM: ☐ AM ☐ PM	
Last Name:	First Name:	Phone Number:	
Street Address:	City:	State:	Zip Codes: / State County:
Date of Birth: / /	Gender: ☐ Male ☐ Female	Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Undefined	

Race: ☐ Black ☐ White ☐ Mixed Race ☐ American Indian/Native Alaskan ☐ Hispanic/Latino ☐ Hawaiian/Pacific Island ☐ Asian ☐ Other/Unknown

Medication allergy:

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

☐ COVID-19 PCR WITH RPP ABR* ☐ COVID-19 WITH RSV A/B & FLU A/B ONLY ☐ RPP WITH ABR* ☐ RPP PCR

☐ ADENOVIRUS 1	☐ HUMAN CORONAVIRUS HKU1	☐ HUMAN PARAINFLUENZA VIRUS 1	☐ INFLUENZA A/H1-2009	☐ SARS-COV-2
☐ ADENOVIRUS 2	☐ HUMAN CORONAVIRUS NL63	☐ HUMAN PARAINFLUENZA VIRUS 2	☐ INFLUENZA A/H3	☐ STAPHYLOCOCCUS AUREUS
☐ BORDETELLA BRONCHISEPTICA	☐ HUMAN CORONAVIRUS OC43	☐ HUMAN PARAINFLUENZA VIRUS 3	☐ INFLUENZA B	☐ STREPTOCOCCUS PNEUMONIAE
☐ BORDETELLA PERTUSSIS	☐ HUMAN ENTEROVIRUS (PAN ASSAY)	☐ HUMAN PARAINFLUENZA VIRUS 4	☐ INFLUENZA C	☐ STREPTOCOCCUS PYOGENES (GROUP A)
☐ CHLAMYDOPHILA PNEUMONIAE	☐ HUMAN ENTEROVIRUS D68	☐ HUMAN PARECHOVIRUS	☐ KLEBSIELLA PNEUMONIAE	☐ STREPTOCOCCUS AGALACTIAE (GROUP B)
☐ COXIELLA BURNETII	☐ HUMAN HERPESVIRUS 3 (HHV3)	☐ HUMAN RESPIRATORY SYNCYTIAL VIRUS A (RSVA)	☐ LEGIONELLA PNEUMOPHILA	☐ STREPTOCOCCUS DYSGALACTIAE (GROUP G)
☐ HAEMOPHILUS INFLUENZAE	☐ HUMAN HERPESVIRUS 4 (HHV4)	☐ HUMAN RESPIRATORY SYNCYTIAL VIRUS B (RSVB)	☐ MYCOPLASMA PNEUMONIAE	☐ ANTIBIOTIC RESISTANCE GENES*
☐ HAEMOPHILUS INFLUENZAE TYPE B	☐ HUMAN HERPESVIRUS 5 (HHV5)	☐ HUMAN RHINOVIRUS 1	☐ MORAXELLA CATARRHALIS	
☐ HUMAN BOCAVIRUS	☐ HUMAN HERPESVIRUS 6 (HHV6)	☐ HUMAN RHINOVIRUS 2	☐ PNEUMOCYSTIS JIROVECII	
☐ HUMAN CORONAVIRUS 229E	☐ HUMAN METAPNEUMOVIRUS (HMPV)	☐ INFLUENZA A	☐ PSEUDOMONAS AERUGINOSA	

ICD 10 Codes: ______________________ ______________________ ______________________ ______________________ ______________________ ______________________

ANTIBIOTIC RESITANCE GENES*

☐ CARBAPENEMS	☐ QUINOLONE	☐ VANCOMYCIN
☐ ESBL	☐ SULFONAMIDE/ TRIMETHOPRIM	☐ AMPC
☐ FOSFOMYCIN	☐ TETRACYCLINE	☐ METHICILLIN
☐ MACROLIDE		

BILLING INFORMATION

Insurance Company:	Group Number:	Policy Number:	☐ Self-Pay
Name of Insured:	Relationship to Insured:	DOB of Insured: / /	☐ Client Direct (Facility Pay)

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.

Print Patient Name:	Print Signature:	Date:

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.

Provider Authorizing Name:	Provider Authorizing Signature:	Date: