CORE BIO LABS
Precise • Comprehensive • Reliable

URINARY TRACT 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

☐ UTI PCR PANEL ☐ CULTURE WITH AST* ☐ UA

Sample Type: ☐ **Vacutainer** ☐ **Urine Sample** ☐ **STI-Penile/Vaginal Swab** (Eswab Kit)

☐ ACINETOBACTER BAUMANNII	☐ CANDIDA PARAPSILOSIS	☐ ENTEROCOCCUS FAECIUM	☐ MYCOPLASMA GENITALIUM	☐ SERRATIA MARCESCENS	☐ STREPTOCOCCUS AGALACTIAE (GROUP B)
☐ BACTEROIDES FRAGILIS	☐ CANDIDA TROPICALIS	☐ ESCHERICHIA COLI	☐ MYCOPLASMA HOMINIS	☐ STAPHYLOCOCCUS AUREUS	☐ STREPTOCOCCUS DYSGALACTIAE (GROUP G)
☐ CANDIDA ALBICANS	☐ CITROBACTER FREUNDII	☐ KLEBSIELLA OXYTOCA	☐ PROTEUS MIRABILIS	☐ STAPHYLOCOCCUS EPIDERMIDIS	☐ STREPTOCOCCUS PNEUMONIAE
☐ CANDIDA AURIS	☐ ENTEROBACTER AEROGENES	☐ KLEBSIELLA PNEUMONIAE	☐ PROTEUS VULGARIS	☐ STAPHYLOCOCCUS COAGULASE-NEGATIVE	☐ UREAPLASMA PARVUM
☐ CANDIDA GLABRATA	☐ ENTEROBACTER CLOACAE	☐ MORAXELLA CATARRHALIS	☐ PROVIDENCIA STUARTI	☐ STAPHYLOCOCCUS SAPROPHYTICUS	☐ UREAPLASMA UREALYTICUM
☐ CANDIDA KRUSEI	☐ ENTEROCOCCUS FAECALIS	☐ MORGANELLA MORGANII	☐ PSEUDOMONAS AERUGINOSA	☐ STREPTOCOCCUS PYOGENES (GROUP A)	☐ **ANTIBIOTIC RESISTANCE GENES***

☐ ADD STI						
☐ CHLAMYDIA TRACHOMATIS	☐ HAEMOPHILUS DUCREYI	☐ MYCOPLASMA HOMINIS	☐ TRICHOMONAS VAGINALIS	☐ UREAPLASMA UREALYTICUM	☐ HERPES VIRUS 1	☐ HPV 16
☐ NEISSERIA GONORRHOEAE	☐ MYCOPLASMA GENITALIUM	☐ TREPONEMA PALLIDUM	☐ UREAPLASMA PARVUM		☐ HERPES VIRUS 2	☐ HPV 18

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: