Absolute Genomics

Place Specimen Label Here

Comprehensive Testing Requisition

PATIENT INFORMATION

Last Name | First Name | MI

Address

City | State | Zip

Phone | DOB (mm/dd/yyyy) | Biological Gender ☐Male ☐Female

Ancestry

☐ African American ☐ Ashkenazi Jewish ☐ Asian ☐ Caribbean ☐ Caucasian
☐ Central/South American ☐ Eastern European ☐ Hispanic ☐ Middle Eastern ☐ Native American
☐ Northern European ☐ Pacific Islander ☐ Western European ☐ Other:_____

PRACTICE INFORMATION

Clinic Name

Physician Name | NPI #

Address | City

State | Phone | Fax

SPECIMEN INFORMATION

Date of Collection (mm/dd/yyyy)
If not provided date will be one day prior to receipt of specimen

Time of Collection ☐AM ☐PM

Collected by: _____

BILLING INFORMATION

☐ Client Billed ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Tricare ☐ Cash Pay

Name of Policy Holder | DOB (mm/dd/yyyy) | Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Dependant ☐ Other_____

Insurance | Member ID # | Group #

TEST ORDER

☐ WOUND *InSITE*

BACTERIA
- ☐ Acinetobacter baumannii
- ☐ Pseudomonas aeruginosa
- ☐ Corynebacterium amycolatum
- ☐ Morganella morganii
- ☐ Serratia marcescens
- ☐ Staphylococcus epidermidis
- ☐ Escherichia coli
- ☐ Klebsiella pneumoniae
- ☐ Salmonella enterica
- ☐ Enterococcus faecalis
- ☐ Enterococcus faecium
- ☐ Staphylococcus aureus
- ☐ Clostridium perfringens
- ☐ Proteus mirabilis
- ☐ Streptococcus agalactiae (GBS)
- ☐ Streptococcus pneumoniae

VIRUSES
- ☐ Candida albicans
- ☐ Candida glabrata
- ☐ Candida parapsilosis
- ☐ Candida tropicalis

Standard Swab w/ VTM Tube

☐ WOMENS *InSITE*

BACTERIA
- ☐ Atopobium vaginae
- ☐ BVAB2
- ☐ Chlamydia trachomatis
- ☐ Enterococcus faecalis
- ☐ Escherichia coli
- ☐ Gardnerella vaginalis
- ☐ Haemophilus ducreyi
- ☐ Mobiluncus curtisii
- ☐ Mobiluncus mulieris
- ☐ Mycoplasma genitalium
- ☐ Mycoplasma hominis
- ☐ Neisseria gonorrhoeae
- ☐ Prevotella bivia
- ☐ Staphylococcus aureus
- ☐ Streptococcus agalactiae (GBS)
- ☐ Treponema pallidum
- ☐ Ureaplasma urealyticum

FUNGI
- ☐ Candida albicans
- ☐ Candida glabrata
- ☐ Candida krusei
- ☐ Candida lusitaniae
- ☐ Candida parapsilosis
- ☐ Candida tropicalis

PARASITE
- ☐ Trichomonas vaginalis

VIRUSES
- ☐ Herpes Simplex Virus 1
- ☐ Herpes Simplex Virus 2

Standard Swab w/ VTM Tube

☐ NAIL *InSITE*

BACTERIA
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Enterococcus faecalis
- ☐ Enterococcus faecium
- ☐ Escherichia coli
- ☐ Klebsiella pneumoniae
- ☐ Pseudomonas aeruginosa
- ☐ Staphylococcus aureus

FUNGI
- ☐ Candida albicans
- ☐ Candida glabrata
- ☐ Candida parapsilosis
- ☐ Candida tropicalis
- ☐ Trichophyton mentagrophytes var. interdigitale
- ☐ Trichophyton mentagrophytes var. menta
- ☐ Trichophyton rubrum
- ☐ Trichophyton schoenleinii
- ☐ Trichophyton tonsurans
- ☐ Trichophyton verrucosum
- ☐ Trichophyton violaceum

Specimen Cup or Tube

☐ URINARY *InSITE*

BACTERIA
- ☐ Acinetobacter baumannii
- ☐ Citrobacter freundii
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Enterococcus faecalis
- ☐ Escherichia coli
- ☐ Haemophilus influenzae
- ☐ Klebsiella pneumoniae
- ☐ Proteus mirabilis
- ☐ Proteus vulgaris
- ☐ Pseudomonas aeruginosa
- ☐ Staphylococcus aureus
- ☐ Staphylococcus saprophyticus
- ☐ Streptococcus agalactiae (GBS)
- ☐ Streptococcus pyogenes

FUNGI
- ☐ Candida albicans
- ☐ Candida glabrata
- ☐ Candida parapsilosis

PARASITE
- ☐ Trichomonas vaginalis

VIRUSES
- ☐ Herpes Simplex Virus 1
- ☐ Herpes Simplex Virus 2

Vacutainer Tube

☐ RESPIRATORY *InSITE*

BACTERIA
- ☐ Bordetella pertussis
- ☐ Chlamydia pneumoniae
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Escherichia coli
- ☐ Haemophilus influenzae
- ☐ Klebsiella pneumoniae
- ☐ Moraxella catarrhalis
- ☐ Mycoplasma pneumoniae
- ☐ Staphylococcus aureus
- ☐ Streptococcus pneumoniae
- ☐ Streptococcus pyogenes

VIRUSES
- ☐ Adenovirus
- ☐ Coronavirus 229E
- ☐ Coronavirus HKU1
- ☐ Coronavirus NL63
- ☐ Coronavirus OC43
- ☐ Enterovirus D68
- ☐ Herpes Simplex Virus 1
- ☐ Herpes Simplex Virus 2
- ☐ Human Herpes Virus 3 (Zoster)
- ☐ Human Herpes Virus 6
- ☐ Human Metapneumovirus
- ☐ Influenza A
- ☐ Influenza A H1
- ☐ Influenza A H3
- ☐ Influenza B
- ☐ Parainfluenza 1
- ☐ Parainfluenza 2
- ☐ Parainfluenza 3
- ☐ Parainfluenza 4
- ☐ Respiratory Syncytial Virus A
- ☐ Respiratory Syncytial Virus B
- ☐ Rhinovirus

FUNGI
- ☐ Candida albicans
- ☐ Candida glabrata
- ☐ Candida parapsilosis

Standard Swab w/ VTM Tube

☐ ABX *ADVANTAGE*

FOX	(Betalactamase Resistance)	ermB	(Macrolide Resistance)	tetS	(Tetracycline Resistance)
IMP-1	(Carbapenemase Resistance)	mecA	(Methicillin Resistance)	qnrA	(Quinolone Resistance)
NDM-1	(Carbapenemase Resistance)	mecC	(Methicillin Resistance)	VanA	(VancomycinResistance)
OXA-1	(Carbapenemase Resistance)	mcr-1	(Polymyxin Resistance)	VanB	(Vancomycin Resistance)
VIM	(Carbapenemase Resistance)	tetB	(Tetracycline Resistance)		
bla-SHV	(Betalactamase Resistance)	tetM	(Tetracycline Resistance)		

ICD-10 CODES

_____ _____ _____ _____ _____ _____

ICD-10 diagnosis codes are required. Providers should order only tests that are medically necessary for the diagnosis and treatment of the patient.

ORDERING CHECKLIST

- ☐ Copy of Patient Demographics
- ☐ Check appropriate panel type
- ☐ ICD-10 Diagnosis Codes
- ☐ Copy of Insurance Card (Front/Back)
- ☐ Medical Provider name and signature
- ☐ Medical Necessity Notes & Medication List

MEDICAL PROVIDER CONSENT

By signing this form, the medical provider acknowledges that the individual/family member authorized to make decisions for the individual (the "Patient") has been supplied information regarding and consented to undergo pathogen testing, as stated in the Absolute Genomics Informed consent for pathogen testing. This test is medically necessary for the risk assessment, diagnosis, or detection of disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. COVID 19 results will be shared with the state of Pennsylvania, CDC, and any other agency that is required by the governing health agencies. 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 Absolute Genomics. As the medical provider, I am responsible for documenting the applicable ICD-10 diagnosis codes. I acknowledge and understand that Absolute Genomics will perform laboratory testing for my patients and sometime this testing will be billed as an out-of-network provider. I acknowledge that I am solely responsible for adhering to any applicable policies, procedures, or protocols for the referral of specimens to an out-of-network laboratory established by commercial payers with whom I or my practice may be contracted. I have made my patient aware of the potential of the Absolute Genomics being a out of network provider and gave the patient the ability to deny the test until a in-network lab provider could be selected. I acknowledge that I and the Patient have been informed and agreed that if the Patient's insurer does not reimburse Absolute Genomics in full for any reason, including if the insurer considers the pathogen test ordered to be a non-covered service or not medically necessary, then Absolute Genomics may bill the patient directly for the services and the Patient will remit payment directly to Absolute Genomics. Test results could be delayed in some circumstances when there is an error in specimen collection, error in specimen collection documentation, error in the collection of 2 or more ICD-10 codes, medical necessity documentation collections, or a delay in shipping and not received by laboratory by 9 am the following morning after collection of sample.

☐ By checking the box the patient opts out of de-identified research purposes. If left blank consent is received.

Medical Provider Signature **Date**