Absolute Genomics

Place Specimen Label Here

Urinary *InSITE* 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
☐ Caucasian
☐ Hispanic
☐ Middle Eastern
☐ Native American
☐ 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 ☐ Dependent ☐ Other_____

Insurance | Member ID # | Group #

TEST ORDER

☐ **Urinary *InSITE***

BACTERIA
- ☐ Acinetobacter baumannii
- ☐ Citrobacter freundii
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Enterococcus faecalis
- ☐ Escherichia coli
- ☐ Haemophilus influenzae
- ☐ Klebsiella pneumoniae
- ☐ Proteus mirabilis
- ☐ Proteus vulgaris

BACTERIA CONTINUED
- ☐ Pseudomonas aeruginosa
- ☐ Staphylococcus aureus
- ☐ Staphylococcus saprophyticus
- ☐ Streptococcus agalactiae (GBS)
- ☐ Streptococcus pyogenes

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

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

PARASITE
- ☐ Trichomonas vaginalis

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

Collected with vacutainer tube

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 Test Order
- ■ 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. 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. 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 sometimes this testing may 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 an out of network provider and gave the patient the ability to deny the test until an 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 or documentation, error in the collection of 2 or more ICD-10 codes, medical necessity documentation 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**