ABSOLUTE GENOMICS

Place Specimen Label Here

Sexual Health 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) | 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 #

Reflex : Syphilis - RPR(Rapid plasma reagin)

TESTING MENU

☐ **Sexual Health *InSITE***

Chlamydia - FECAL	Gonorrhea - FECAL
Chlamydia - OROPHARYNGEAL	Gonorrhea - OROPHARYNGEAL
Chlamydia - URINE	Gonorrhea - URINE
Creatinine	HcG (pregnancy test)**
Hep B	HIV
Hep C	Syphilis Antibody*

Reflex: Syphilis - RPR (Rapid Plasma Reagin)

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

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.

AUTOMATIC REFLEX: A laboratory test that is automatically obtained when the results of a screening test indicate the need for further study. The outcome of the first test will determine if reflex testing is needed for any particular pathogen gene(s). *If Syphilis Antibody is indicated as a positive the test will be reflexed to test for Syphilis - RPR (Rapid Plasma Reagin) ** HcG will only be tested on biological Females

NOTE: Samples must be received by Absolute Genomics by 11am EST to go into testing same day. Expect results <48 hours from receipt

For Rectal Swab Collection:

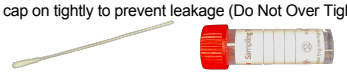
1. Peel open the kit package and remove the tube of medium and the flocked swab applicator
2. Use the flocked swab to collect the clinical specimen. The operator must touch the swab applicator only above the marked breakpoint line (the area from the line to the end of the swab shaft), which is the opposite end to the nylon fiber tip.
3. Insert the flocked swab through the rectal sphincter 2,5 to 3,5 cm (1-1.4inches) and gently rotate. NOTE: the rectal flocked swab has a plastic ring on the shaft which is a marker for the maximum depth for the rectal sampling. Do not insert the rectal swab beyond this marker.
4. Withdraw and examine to make sure there is fecal material visible on the tip.
5. After collection, transfer the swab into the tube with the preservation medium and visually check that the maximum filling line (“MAX. FILL”) indicated on the label is not exceeded.
6. Holding the swab shaft between thumb and finger, mash and mix the stool specimen against the side of the tube to evenly disperse and suspend the specimen in the preservation medium.
7. Break the swab off into the tube
8. Place the screw cap on the tube and tighten.
9. Shake the vial until the sample appears homogeneous.
10. Write patient’s name and demographics on the tube label and send sample to the laboratory.

For Urine Vacutainer Collection:

1. Place sterile container with urine on a clean, flat surface.
2. Do not touch tip of transfer straw (it must remain sterile).
3. Place the tip of the transfer straw into the urine specimen ensuring the transfer straw does not touch the side of the container.
4. Push tube into the holder, stopper down. Advance the tube over the puncture point to pierce the stopper.
5. Hold tube in position until the flow stops (filled). The urine MUST meet the minimum fill line of 4 ml to be valid. Overfilling the transport tube will invalidate the test. Under filled tube will not be processed.
6. Remove tube from the holder, leaving the transfer straw in the specimen container.
7. Mix the tube 8-10 times by inversion.
8. Ensure urine vacutainer tube is correctly labeled (check labels and names with initial collection container to ensure that the correct label is applied to the aliquot).
9. Lift the transfer straw in the original container and allow specimen to drain. Discard transfer straw into biohazard container approved for sharps disposal.
10. Screw the cap on tightly to prevent leakage
11. Discard remaining urine down drain.

For Oral Swab Collection:

1. Tilt head back 70 degrees and insert the swab into mouth, swabbing the area past the posterior pharynx and tonsillar areas. Take care to avoid the tongue.
2. Saturate the swab by swirling it gently for up to 10 seconds for maximum specimen collection.
3. Remove the screw cap from the tube and insert the swab all the way to the bottom of the VTM tube.
4. Hold the tube away from your face. Holding the end of the swab shaft, bend it at a 180 degrees angle to break at the marked break point.
5. Screw the cap on tightly to prevent leakage (Do Not Over Tighten)



For Dried Blood Collection:

1. Layout the content of blood kit (alcohol swab, bandage, blood card, lancet, barcode sticker)
2. Print your name, date of birth, date of collection and stamp the barcode sticker on card
3. Use the provide alcohol pad to clean the tip of the finger (3rd or 4th finger). Let it dry out
4. Prick using the lancet provided and gently press the pricked finger from below the puncture site to allow for a large drop of blood to form
5. Hold finger downward to allow blood to drop into circles on the blood card. Please fill out all five circles.
6. Let the blood to dry out and then seal the card and put in biohazard box.
7. Wipe the puncture site with alcohol swab and put a bandage.

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. 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 11 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**