

## Comprehensive Testing Requisition

PATIENT INFORMATION						PR/	ACTICE	NFORM.	ATION	
Last Name First N	lame		MI	Clinic Name	Э					
Address				Physician Name					NPI #	<del></del>
City	State	Zip		Address					City	
Phone	DOB (mm/dd/yyyy)	Biological Gender	□Male □Female	State		Phone		F	ax	
Ancestry African American Central/South American Northern European						SPE	CIMEN	NFORM	ATION	
☐ Ashkenazi Jewish ☐ Ea ☐ Asian ☐ Hi ☐ Caribbean ☐ Mi	stern European	Pacific Islande Western Euro Other:	er er	Date of Collection	(mm/do	d/yyyy)	Time of Collection	□ A □ P		ed by:
		BILI	LING INI	FORMA	ΓΙΟΝ					
Name of Policy	☐ Client Billed ☐	1		care □Me						
Holder			DOB (mm/c	dd/yyyy)	Rela		to Policy Ho Spouse $\Box$		☐ Othe	r
Insurance		_		Member	ID#			Group #		
			TESTING	MENU						
AUTOMATIC REFLEX: A laboratory test that is au particular pathogen gene(s).	tomatically obtained when the					study. The o		rst test will dete reflex any re		testing is needed for any
NOTE: COVID samples must be re						camo das		-		rocoint
NON-COVID samples mus										
□ COVID 19	□WOUND InSI	ΓΕ				Y InSIT		OMENS /	InSITE	
Nasal Swab w/ VTM Tube	Wound Location:			Acine	TERIA tobacter acter fre	baumannii*	Ator	CTERIA oobium vaginae AB2*	e*	FUNGI Candida albicans
BACTERIA Bordetella pertussis* Bordetella pertussis* Bordetella bronchiseptica / parapertussis* Chlamydia pneumoniae* Haemophilus influenzae* Klebsiella pneumoniae* Legionella pneumophila* Mycoplasma pneumoniae* Staphylococcus aureus* Streptococcus pneumoniae* VIRUSES Adenovirus Coronavirus 229E Coronavirus NL63 Coronavirus NL63 Coronavirus OC43 Enterovirus D68 Enterovirus (pan assay) Human Herpes virus 4 (Epstein-Barr Virus Human Herpes virus 5 (Cytomegalovirus) Human Herpes Virus 6 Human Metapneumovirus Influenza A Influenza A H1 Influenza B Parainfluenza 1 Parainfluenza 1 Parainfluenza 2 Parainfluenza 3 Parainfluenza 4 Respiratory Syncytial Virus B Rhinovirus	Trichophyton rubrum Trichophyton tonsurans Trichophyton verrucosi	popa* s W/ MRSA* midis* * ae (GBS)* niae*  phytes var. in phytes var. m s mab w/ VTM To Candida a Candida a Candida a Candida a Trichophyt var. m s sa* Trichophyt var. m Trichophyt var. m	albicans glabrata parapsilosis ropicalis on mentagrophy terdigitale on mentagrophy	Entern Entern Esche Haem Klebs Protei Candi BVAB: Chlam Gardn Mycop Neisse Ureappi FUNG Candi Candi PARA Tricho VIRUS	bbacter cococcus is cococcus is cococcus is cococcus is crichia cocophilius in iella pneu us mirabi us vulgar domonas ylococcus ylococcus cococcus ida albica da glabra da glabra da glabra se simple se simple cococcus cococcus ida cococcus cococcus ida cococcus ida glabra da parape site da parape site site situation da glabra da parape site situation da glabra da parape site site situation da glabra da parape site site situation da glabra da parape site situation da glabra da parape site site situation da glabra da parape site situation da glabra da g	faecalis* li* nfluenzae* umoniae* lis* is* aeruginosa s aureus* s saprophyt agalactiae(i pyogenes* ans ata sisilosis ix Virus 1 ex Virus 2  **Tube*  TE  inae* homatis* ginalis* enitalium* ominis* rrhoeae* ealyticum* ns silosis aginalis	* Moto Myc Myc Neis Pres Star GBS)* Trep Ure:	Vacutainer Tu IC	* is* alium* nis* nise* viceae* viceae	ard Swab w/ VTM Tube
Standard Swab w/ VTM Tube	Specime		ton verrucosun	n Herpe: Herpe: Vacutainer Tu	s Simple: s Simple: ube or Stan	x Virus 1 x Virus 2 dard Swab w/ N	/TM Tube	■ Copy of	Patient Den	nographics
ABX ADVANTAGE  FOX (Betalactamase Resistance)	mecA (Methicillir mecC (Methicillir	mase Resista n Resistance) n Resistance) n Resistance)	Yan Van		cinResist	tance)		<ul><li>■ ICD-10 D</li><li>■ Copy of I</li><li>■ Medical P</li></ul>	Provider nam	anel type odes ard (Front/Back) ne and signature otes & Medication List
			AL PROV							
By signing this form, the medical provider acknowle pathogen testing, as stated in the Absolute Genomic or disorder. The results will determine my patient's	dges that the individual/family n	nember authorizen testing. This	ed to make decis test is medically	sions for the indiv necessary for the	vidual (the	"Patient") has	s been supplied i	nformation regar	ding and conse	ented to undergo

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 of sample.

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

Medical Provider Signature or Authorized Individual Signature (Must have a completed Ordering Facility and Provider Order Authorization form)