RPP MOLECULAR TEST REQUISITION

HDx Labs

Clinic: _____

Address: _____

Phone: _____

Provider: _____

PATIENT INFORMATION

☐ Male ☐ Female

First: _____ Last: _____

DOB: _____ SSN: _____

Email: _____ Phone: _____

SPECIMEN COLLECTION

Collector: _____

Date/Time: _____

Date Received:

BILLING

☐ PATIENT ☐ CLINIC ☐ WORKERS COMP: _____

☐ INSURANCE ***Include a copy of front and back of insurance card

Company _____

Policy # _____ Group# _____

MEDICATIONS

RPP PANEL with ABR Reflex

**RPP SWAB KIT REQUIRED*

☐ Nasopharyngeal Swab ☐ Oropharyngeal Swab

See ICD-10 CODE LIST indicating if **BOTH NASAL AND THROAT SWAB are recommended for testing optimization and diagnosis.

VIRUSES

- ☐ *Adenovirus*
- ☐ *Bocavirus*
- ☐ *Coronavirus (229E)*
- ☐ *Coronavirus (HKU1)*
- ☐ *Coronavirus (NL63)*
- ☐ *Coronavirus (OC43)*
- ☐ *Influenza A&B*
- ☐ *Metapneumovirus A&B*
- ☐ *Parainfluenza virus 1,2,3 4*
- ☐ *Parechovirus*
- ☐ *Rhinovirus / Enterovirus*
- ☐ *Human RSV A&B*

BACTERIA

- ☐ *Bordetella pertussis/holmesii*
- ☐ *Chlamydia pneumoniae*
- ☐ *Haemophilus influenzae*
- ☐ *Klebsiella pneumoniae*
- ☐ *Legionella*
- ☐ *Moraxellis catarrhalis*
- ☐ *Mycoplasma pneumoniae*
- ☐ *Salmonella spp.*
- ☐ *Staphylococcus aureus*
- ☐ *Streptococcus pneumoniae*

ICD-10 CODES ARE REQUIRED

Select ALL Applicable Codes

- ☐ J01.90 - Acute sinusitis, unspecified
- ☐ J02.9 - Acute pharyngitis *(Nasal & Throat Swab)*
- ☐ R06.02 - Shortness of breath *(Nasal & Throat Swab)*
- ☐ J06.9 - Acute upper respiratory infection *(Nasal &Throat Swab)*
- ☐ J18.9 - Pneumonia, unspecified org.*(Nasal &Throat Swab)*
- ☐ Z20.822 - Contact or suspected exposure to COVID-19
- ☐ R07.81 - Pleurodynia
- ☐ J12.9 - Viral pneumonia, unspecified *(Nasal &Throat Swab)*
- ☐ R05.1 - Acute cough *(Nasal & Throat Swab)*
- ☐ R05.9 - Cough, unspecified *(Nasal & Throat Swab)*
- ☐ R50.9 - Fever *(Nasal & Throat Swab)*
- ☐ J98.8 -Other specified respiratory disorder *(Nasal & Throat Swab)*
- ☐ D64.89 - Other specified anemias
- ☐ D70.9 - Neutropenia, unspecified
- ☐ D84.821 - Immunodeficiency due to drugs
- ☐ D84.89 - Other immunodeficiency
- ☐ E10.43-Type 1 diabetes mellitus diabetic autonomic (poly)neuropathy
- ☐ E11.43-Type 2 diabetes mellitus diabetic autonomic (poly)neuropathy
- ☐ J45.991 - Cough variant asthma *(Nasal & Throat Swab)*
- ☐ J84.89 - Other specified interstitial pulmonary disease
- ☐ J84.10 - Pulmonary fibrosis, unspecified
- ☐ Other: _____
- ☐ Other: _____

ANTIBIOTIC RESISTANCE GENES

Auto Reflex with Positive Pathogen

- *Klebsiella pneumoniae carbapenemase*
- *Methicillin Resistance*
- *Sulfhydryl Variable-B-lactamase*
- *Vancomycin Resistance (Van A and Van B)*
- *Verona integron-encoded metallo-B-lactamase*

PROVIDER ATTESTATION: The requested tests are medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. My signature below indicates that I am the referring physician or authorized health care provider. I have explained the purpose of the testing to my patient. My patient has been given the opportunity to ask questions and/or seek further counsel and has has voluntarily decided to have the testing performed by HDx Labs. As the medical provider, **I am responsible for documenting applicable ICD-10 diagnosis codes.**

PROVIDER SIGNATURE: _____ **DATE:** _____

REQUIRED DOCUMENTATION:

1) Clear copy of front & back of patient insurance card
2) Copy of patient's demographics
3) Copy of current driver's license
4) Prior Authorization or Accident Form (if applicable)
5) If Worker's Comp. claim, SSN required in Patient Info

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