UTI-STI 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

UTI/STI PANEL with ABR Reflex

Bacteria

- ☐ *Morganella morganii*
- ☐ *Haemophilus ducreyi*
- ☐ *Chlamydia trachomatis*
- ☐ *Gardnerella vaginalis*
- ☐ *Klebsiella oxytoca*
- ☐ *Klebsiella pneumoniae*
- ☐ *Enterobacter cloacae*
- ☐ *Enterococcus faecalis*
- ☐ *Mycoplaasma hominis*
- ☐ *Mycoplasma genitalium*
- ☐ *Neisseria gonorrhoeae*
- ☐ *Escherichia coli*
- ☐ *Proteus mirabilis*
- ☐ *Providencia stuartii*
- ☐ *Pseudomonas aeruginosa*
- ☐ *Serratia marcescens*
- ☐ *Staphylococcus aureus*
- ☐ *Staphylococcus saprophyticus*
- ☐ *Streptococcus agalactiae*
- ☐ *Treponema pallidum*
- ☐ *Ureaplasma urealyticum*

Viruses

- ☐ *Herpes simplex virus 1*
- ☐ *Herpes simplex virus 2*

Fungi

- ☐ *Candida glabrata*
- ☐ *Candida parapsilosis*
- ☐ *Candida tropicalis*
- ☐ *Candida albicans*

Other

- ☐ *Trichomonas vaginalis*

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*

ICD-10 CODES MUST BE SELECTED

URINE CODES: Select Applicable Codes

- ☐ N30.00 - Acute cystitis w/o hematuria
- ☐ N30.01 - Acute cystitis w/ hematuria
- ☐ N30.20 - Other chronic cystitis w/o hematuria
- ☐ N30.21 - Other chronic cystitis w/ hematuria
- ☐ N39.0 - Urinary tract infection, site not specified
- ☐ R30.9 - Painful micturition, unspecified
- ☐ R35.0 - Frequency of micturition
- ☐ R39.15 - Urgency of urination
- ☐ N89.8 - Other specified non-inflammatory disorder of vagina
- ☐ N34.2 - Other urethritis
- ☐ N76.89 - Other specified inflammation of vagina/vulva
- ☐ B37.49 - Other urogenital candidiasis
- ☐ R10.2 - Pelvic and perineal pain
- ☐ R30.0 - Dysuria
- ☐ R36.9 - Urethral discharge, unspecified
- ☐ N76.81 - Mucositis (ulcerative) of vagina/vulva
- ☐ N76.5 - Ulceration of vagina
- ☐ A59.09 - Other urogenital trichomoniasis
- ☐ A51.31 - Condyloma laturn
- ☐ A56.2 - Chlamydial infection genitourinary tract, unspecified
- ☐ A60.00 - Herpes viral infection urogen system, unspecified
- ☐ A64 - Unspecified sexually transmitted disease
- ☐ Z11.3 - Encounter screen for infections w/sexual transmission

☐ Other:_____

☐ Other:_____

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

HDX Labs

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HDx Labs