LabGenomics

UTI

U0000016404
CLIA ID# 31D2026917

PATIENT INFORMATION *(REQUIRED)*

Date of Collection: _____ Time of Collection: _____

Cell #: _____ Email: _____

Home #: _____ Street Address: _____

Apt: _____ City: _____ State: _____ Zip: _____

DOB (MM/DD/YYYY): _____ / _____ / _____ SSN #: _____

(SSN # required for uninsured patients only)

Gender Identity and Sexual Orientation

- ☐ Male
- ☐ Female
- ☐ Non-Binary/Genderqueer
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Bisexual
- ☐ Other: _____

Race and Ethnicity — Select all that apply

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other: _____

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

REFERRING PHYSICIAN INFORMATION *(REQUIRED)*

INSURANCE INFORMATION *(REQUIRED)*

Policyholder Name: _____

Insurance Name: _____

Policy #: _____

Group #: _____

Please provide a copy of the front & back of insurance card(s).

- ☐ Bill Insurance
- ☐ Bill Client
- ☐ Self Pay

SPECIMEN ID:

16865 Rev E

LAB ACCESSION #:

_____

CC REPORT

Practice/Surgery Center: _____

Street Address: _____

City: _____ State: _____ Zip: _____

URINARY TRACT INFECTION PATHOGEN PANEL (26 Targets)

☐ **COMPLETE PANEL**

BACTERIA

- Acinetobacter baumannii
- Citrobacter freundii
- Enterobacter aerogenes
- Enterobacter cloacae
- Enterococcus faecalis
- Enterococcus faecium
- Escherichia coli
- Klebsiella oxytoca
- Klebsiella pneumoniae
- Morganella morganii
- Mycoplasma genitalium
- Proteus mirabilis
- Proteus vulgaris
- Pseudomonas aeruginosa
- Providencia stuartii
- Staphylococcus aureus
- Staphylococcus saprophyticus
- Streptococcus agalactiae
- Streptococcus pyogenes
- Ureaplasma urealyticum
- Urealpasma parvum

YEAST

- Candida albicans
- Candida glabrata

STI

- Chlamydia trachomatis
- Neisseria gonorrhoeae
- Trichomonas vaginalis

☐ **PANEL WITHOUT STI**

ANTIBIOTIC RESISTANCE GENES

ampC	ermC	QnrS	vanC1
blaOXA-48	KPC	tetM	SULL
ermA	mecA	vanA2	DFRA
ermB	QnrA	vanB	

Please see the reverse side for Antibiotic Resistance Gene Correlation.

STATEMENT OF MEDICAL NECESSITY *(REQUIRED FOR TESTING)*

Must check off at least one essential ICD-10 Code. Test will not be process w/o properly marked Statement of Medical Necessity:

- ☐ N30.00 Acute cystitis without hematuria
- ☐ N30.01 Acute cystitis with hematuria
- ☐ N39.0 Urinary tract infection, site not specified
- ☐ R30.0 Dysuria
- ☐ R31.0 Gross hematuria
- ☐ R35.0 Frequency of micturition
- ☐ R39.15 Urgency of Urination
- ☐ R82.90 Unspecified abnormal findings in urine
- ☐ Z87.440 Personal history of urinary (tract) infections

Additional Primary ICD-10 Codes:

- ☐ N30.10 Interstitial cystitis (chronic) without hematuria
- ☐ N30.11 Interstitial cystitis (chronic) with hematuria
- ☐ N41.1 Chronic prostatitis
- ☐ R30.9 Painful micturition, unspecified
- ☐ R31.9 Hematuria, unspecified
- ☐ R35.1 Nocturia
- ☐ R39.9 Unspecified symptoms and signs involving the genitourinary system
- ☐ Z11.51 Encounter for screening for human papillomavirus (HPV)
- ☐ Z16.30 Resistance to unspecified antimicobial drugs
- ☐ Z20.2 Contact with and (suspected) exposure to infections with prdominantly sexual mode of transmission
- ☐ Other: _____

BOTH PATIENT AND PHYSICIAN MUST SIGN TO APPROVE TESTING

By signing below, I confirm I have read the ABN on the reverse side.

Patient Signature: _____

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to LabGenomics and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Physician Signature: _____

CMS requires physician signature on all requisitions. LabGenomics is responsible for verifying signature prior to performing testing.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.labgusa.com

PEEL LABEL HERE ▼

U0000016404

16865 Rev E

Patient Name/DOB: _____
Cell Number: _____
Collection Date: _____

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LabGenomics

***ANTIBIOTIC RESISTANCE GENE CORRELATION**

GENE DETECTED	CLASS OF ANTIBIOTICS	EXAMPLE OF ANTIBIOTICS
AmpC	Cephalosporins	Cephalexin, cefdinir, cefazolin, cefixime, ceftriaxone, cefoxitin
blaOXA-48, KPC	Carbapenems	Meropenem, ertapenem, imipenem
ermA, ermB, ermC	Macrolides and lincosamide	Erythromycin, azithromycin, clindamycin
mecA	Methicillin	Methicillin, oxacillin, cephalexin, efazolin
QnrA, QnrS	Fluoroquinolones	Levofloxacin, ciprofloxacin, delafloxacin moxifloxacin
vanA, vanB, vaneO	Glycopeptide	Vaneomycin
SULL, DFRA	Sulfamethoxazole/trimethoprim	Bactrim
tetM	Tetracycline	Minocycline, doxycycline

ADVANCED BENEFICIARY NOTICE OF PAYMENT (ABN):

NOTE: This is to notify that your healthcare provider has good reason to think you take the test(s).

Notifier: _____ Date: _____

Patient Name: _____

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Check the box below if you would like to receive the item(s) listed in **TYPE OF TEST** section.

☐ **I WANT THE TEST(S) ORDERED BY MY PHYSICIAN/PROVIDER**
LabGenomics will bill your insurance.

- Signing below means that you have received and understand this notice.

Signature: _____ Date: _____