

TEST REQUEST FORM

Patient Information			
Name (Last, First, MI)			
Address			Birthday
City	State	Zip	<input type="checkbox"/> Male <input type="checkbox"/> Female
Guardian name if minor			Phone
ICD-9 Code(s) Required 1) 2) 3) 4) 5) 6) 7) 8)			
Ordering Physician			
Name (Last, First)			
Address			Phone
City	State	Zip	NPI#
Special Instructions			Fax results to
Payment			
<input type="checkbox"/> Bill Facility Directly			
Name			Acct #
Address			Phone
City	State	Zip	
<input type="checkbox"/> Pre-Pay Attach check or credit card information			Authorization Signature
Credit card number			Exp date
<input type="checkbox"/> Attach copy of front and back of Medicare or insurance card(s). Medicaid not accepted.			
Name of Primary Insurance _____			
Name of Secondary Insurance _____			
Specimen Information	Assays		
Date Collected	<input type="checkbox"/> 7500 Adenovirus qPCR <input type="checkbox"/> 1500 Parvo B19 qPCR <input type="checkbox"/> 2500 BKV qPCR <input type="checkbox"/> 2000 Pneumocystis jiroveci (PCP) qPCR <input type="checkbox"/> 2300 BK IgG Antibody <input type="checkbox"/> RV00 Respiratory Viral Panel <input type="checkbox"/> 5500 CMV qPCR Metapneumovirus <input type="checkbox"/> 4500 EBV qPCR Rhinovirus <input type="checkbox"/> 1400 Enterovirus qPCR Influenza A <input type="checkbox"/> 1100 HBV qPCR Influenza A subtype H1 <input type="checkbox"/> 1300 HCV Genotyping Influenza A subtype H3 <input type="checkbox"/> 1200 HCV RNA qPCR Influenza B (Must be ordered with 1200 HCV RNA qPCR) RSV A <input type="checkbox"/> 6500 HHV-6 qPCR RSV B <input type="checkbox"/> 7000 HHV-7 qPCR Parainfluenza 1 <input type="checkbox"/> 8000 HHV-8 qPCR Parainfluenza 2 <input type="checkbox"/> 8500 HSV 1 / HSV 2 qPCR Parainfluenza 3 <input type="checkbox"/> 9000 ImmuKnow® Adenovirus <input type="checkbox"/> 3500 JCV qPCR <input type="checkbox"/> 3000 SV-40 qPCR <input type="checkbox"/> 9500 VZV qPCR <input type="checkbox"/> 2200 Toxoplasma gondii qPCR		
Time Collected <input type="checkbox"/> AM <input type="checkbox"/> PM			
<input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> CSF <input type="checkbox"/> Bone Marrow <input type="checkbox"/> Tissue <input type="checkbox"/> NP Swab <input type="checkbox"/> Other _____			
Additional Information			