GENESIS
REFERENCE LABORATORIES
P: (844) 232-7130 | FAX: (407) 289-4082
WWW.GENESISREFERENCELABS.COM
7924 FOREST CITY RD | SUITE 210 | ORLANDO, FL 32810
CLIA: 10D2102433

PEEL HERE

PB 01001

PB 01001

Print Patient Name

Date (Mo. - Day Yr.)

PB 01001

FACILITY NAME:
ADDRESS:
PHYSICIAN NAME:

RESPIRATORY PATHOGEN REQUISITION

PATIENT INFORMATION

Last Name	First Name	MI
Street Address	City State	Zip Code
Date of Birth	Gender ☐ Male ☐ Female	

BILLING & INSURANCE INFORMATION

Insurance: Please attached front and back copies of primary and secondary insurance cards. ☐ Demographics Attached Medicare #

I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own and has not been adulterated in any manner. I certify that the information provided on this form and on the specimen, is accurate. I further authorize Genesis Reference Laboratories, to release the results of this testing to the ordering facility and/or my insurance company. I authorize my insurance company to pay and mail directly to Genesis Reference Laboratories and its affiliated laboratories all benefits for payment of services rendered. I also authorize Genesis Reference Laboratories and its affiliated laboratories to endorse any checks received on my behalf for payment of services provided. I hereby irrevocably assign to Genesis Reference Laboratories and its affiliated laboratories all benefits under any policy of insurance indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action including a legal suit, if for any reason my insurance company fails to make payment to benefits due. This assignment also includes all rights to recover attorney fees and costs for such action brought by the provider as my assignee.

I understand that my health insurance plan pays for medically necessary diagnostic tests ordered by my physician after consulting with me and after using the results of the tests in the management of my specific medical need. I understand that my health insurance plan might not cover routine screening tests that are not directed toward my personal symptoms or medical history. Genesis Reference Laboratories will offer me an Advance Beneficiary Notice of Noncoverage (ABN) upon my request if I am a Medicare beneficiary and there is a reasonable question as to whether the testing ordered by my physician will not be a covered benefit under my health plan.

My physician has explained to me the benefits and potential risks of the tests ordered and I consented to such testing with the full understanding of those benefits and risks. Based upon such informed consent I waive any right to claim that Genesis Reference Laboratories lacked my authorization to test my specimen(s) as ordered by my physician.

Patient Signature (Required) _____ Date: _____

ICD-10 CODES

_____ _____

SPECIMEN INFORMATION

Collector: Collection Date: Time: AM / PM

SAMPLE COLLECT ON TYPE

☐ Nasopharyngeal Swab (may be used for any test on respiratory panel) ☐ Saliva Tube (only used for testing COVID, for all other tests please use nasopharyngeal swab)

ORDER SELECTION - PCR

☐ **VIRAL TARGETS ONLY**

Influenza (A, H1-2009,H3)
Influenza B
Parainfluenza (1,2,3,4)
Adenovirus
Bocavirus
Coronavirus (HKU1/NL63/229E/OC93/COVID-19)
Rhinovirus/Enterovirus
Parechovirus
Respiratory syncytial virus
Metapneumovirus

☐ **BACTERIAL TARGETS ONLY**

Mycoplasma pneumoniae
Chlamydia pneumoniae
Streptococcus pneumoniae
Klebsiella pneumoniae
Haemophilus influenza
Legionella pneumophila/longbeachae
Moraxella catarrhalis
Bordatella species*
Staphlococcus aureus

☐ **FULL RESPIRATORY PANEL**
This includes all listed bacterial + viral pathogens.

☐ **COVID ONLY**

** Includes: bronchiseptica, parapertussis, pertussis, holmesii*

☐ **COVID THEN REFLEX TO MODERATE ASSESSMENT**

Sample will be tested for COVID first. If COVID positive, no further testing will be done and result will be reported. If COVID negative, sample will be tested for the following nine common bacterial and viral pathogens.

Parainfluenza (1,2,3,4)
Influenza A virus
Influenza B virus
Respiratory syncytial virus
Rhinovirus/Enterovirus
Streptococcus pneumoniae
Chlamydia pneumoniae
Legionella pneumophila
Haemophilus influenzae

☐ **MODERATE ASSESSMENT**
Regardless of COVID status

REQUESTING PROVIDER INFORMATION

Physician Signature:	Physician Print:	Date: