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CLIA#: 26D1101943
COLA#: 21428
Lab Director: Guihua M. Cao, MD

PRACTICE INFORMATION — REQUIRED

Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PHYSICIAN INFORMATION — REQUIRED

Physician Name: _____ NPI: _____

Physician Name: _____ NPI: _____

Physician Name: _____ NPI: _____

RESPIRATORY TRACT INFECTION > RT-PCR LABORATORY REQUISITION FORM

1 PATIENT INFORMATION — REQUIRED

Last Name: _____

First Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Bill Type: ☐ Insurance ☐ Self-Pay ☐ Client Bill

ATTACH A COPY OF THE PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

3 COLLECTION INFO — REQUIRED

Collection Method

Select ONLY one collection method per patient.

☐ Swab ☐ Saliva

Collectors Initials: _____

Collection Date/Time

Date: _____

Time: _____

☐ AM ☐ PM

2 DIAGNOSIS (ICD-10) CODES (MEDICALLY NECESSARY) — REQUIRED

Select ICD-10 code associated with the required test panel. Additional ICD-10 codes are available on the back side of this form and can be entered in the (Other) field below.

- ☐ R05.00 Cough
- ☐ R06.00 Dyspnea, unspecified
- ☐ R06.02 Shortness of breath
- ☐ R06.9 Abnormal of breathing, unspecified
- ☐ R07.81 Pleurodynia
- ☐ R07.82 Intercostal chest pain
- ☐ R09.3 Abnormal sputum
- ☐ R41.82 Altered mental status, unspecified
- ☐ R50.9 Fever, unspecified
- ☐ R53.82 Chronic fatigue, unspecified
- ☐ R68.83 Chills (without fever)
- ☐ J00 Acute nasopharyngitis
- ☐ J01.90 Acute sinusitis, chronic
- ☐ J02.9 Acute pharyngitis
- ☐ J03.90 Acute tonsillitis
- ☐ J06.9 Acute upper respiratory infections of unspecified site
- ☐ J31.0 Unspecified rhinitis
- ☐ J32.9 Unspecified sinusitis, chronic
- ☐ Z11.52 COVID-19 testing for asymptomatic patients prior to inpatient admissions, planned outpatient procedures and immunosuppressant therapies
- ☐ Z20.822 Contact with and (suspected) exposure to COVID-19
- ☐ Other: _____

4 TEST ORDER — SELECT ONE OR MORE (REQUIRED)

☐ **COVID-19 (SARS_CoV-2) ONLY** If you chose this option proceed to STEP 5 (Patient Acknowledgement)

☐ **COVID-19 (SARS_CoV-2) / FLU A & B / RSV A & B (PCR Panel)** If you want to test specific pathogens select each of them below.

- ☐ COVID-19 (SARS_CoV2)
- ☐ Influenza A/H1-2009
- ☐ Influenza A/H3
- ☐ Influenza B
- ☐ Human Respiratory Syncytial Virus A RSV-A
- ☐ Human Respiratory Syncytial Virus B RSV-B

☐ **RESPIRATORY TRACT INFECTION (Comprehensive PCR Panel)** If you want to test specific pathogens select them below. (ABR PCR Panel add on Available)

VIRUSES

- ☐ COVID-19 (SARS_CoV2)
- ☐ Influenza A/H1-2009
- ☐ Influenza A/H3
- ☐ Influenza B
- ☐ Human Respiratory Syncytial Virus A RSV-A
- ☐ Human Respiratory Syncytial Virus B RSV-B
- ☐ Human Coronaviruses (OC43, HKU1, 229E, NL63, MERS_CoV, SARS_CoV2)
- ☐ Human Parainfluenza Virus (1, 2, 3, 4)
- ☐ Human Herpesvirus 3 HHV3 - Varicella zoster Virus
- ☐ Human Herpesvirus 4 HHV4 - Epstein-Barr Virus
- ☐ Human Herpesvirus 6 HHV6
- ☐ Human Enterovirus (panel), D68

VIRUSES (Continued)

- ☐ Adenovirus 1, 2
- ☐ Human Bocavirus
- ☐ Human Rhinovirus 1, 2
- ☐ Measles virus
- ☐ Mumps virus
- ☐ Human parechovirus
- ☐ Human Metapneumovirus (hMPV)

BACTERIA

- ☐ Bordetella panel (B. bronchiseptica, B. Parapertussis and B. Pertussis)
- ☐ Bordetella (pertussis, holmesii)
- ☐ Mycoplasma pneumoniae

BACTERIA (Continued)

- ☐ Moraxella catarrhalis
- ☐ Haemophilus influenzae
- ☐ Streptococcus pneumoniae
- ☐ Coxiella burnetii
- ☐ Chlamydophila pneumoniae
- ☐ Klebsiella pneumoniae
- ☐ Legionella pneumophila
- ☐ Staphylococcus aureus
- ☐ Streptococcus pyogenes

FUNGUS

- ☐ Pneumocystis

☐ **RESPIRATORY TRACT INFECTION (Viruses Only PCR Panel)**

Refer to RESPIRATORY TRACT INFECTION (Comprehensive PCR Panel) above for full Virus List that will be run on this (Viruses Only PCR Panel)

☐ **Antibiotic Resistance (ABR) PCR Panel** ABR PCR Panel can only be ordered with the COMPREHENSIVE PCR PANEL

- ampC, ACC, ACT/MIR (Ampicillin Resistance)
- BlaNDM-1, GES, CTX-M 1, 2, 8/25, 9, PER 1, VEB, blaFOX, CMY/LAT/MOX (Extended-Spectrum-Betalactamase Resistance)
- Sul 1, 2 (Sulfonamide Resistance:)
- dfrA1, 5 (Trimethoprim Resistance)
- blaOXA-48, Imp 1, Imp2, KPC, NDM, OXA-48, OXA-51, VIM (Carbanpenem Resistance)
- Cfr (Phenicol and Lincosamide Resistance)
- ermA, ermB, ermC (Macrolide Resistance)
- tetM, tetS (Tetracycline Resistance)
- QnrA, QnrB1, QnrB2, QnrB3, QnrB4 (Quinolone Resistance)
- Mcr-1 (Polymyxin Resistance)
- VanA1, VanB (Vancomycin Resistance)
- mecA, mecC (femA for MRSA detection) (Methicillin Resistance)

7 PATIENT ACKNOWLEDGEMENT — REQUIRED

This specimen was provided voluntarily for analysis and I authorize AIM Laboratories to process, bill and provide results. I agree to the declarations and terms in the patient acknowledgment and irrevocable assignment of benefits on the back of this form.

Patient Signature: x _____

Date: _____

Patient Name: _____

Date of Birth: _____

BARCODE - FOR POSITION ONLY
B A R C O D E

8 AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGMENT — REQUIRED

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

Provider Signature:

x _____

Date: _____

Patient Name (Label 1): _____

Date of Birth: _____

Label 1

BARCODE - FOR POSITION ONLY
B A R C O D E

Patient Name (Label 2): _____

Date of Birth: _____

Label 2

BARCODE - FOR POSITION ONLY
B A R C O D E

DIAGNOSIS (ICD-10) CODES

The ICD-10 codes provided below are based on AMA guidelines and are for information purposes only.
ICD-10 coding is the sole responsibility of the ordering provider.

RESPIRATORY

( ) R50.9 Fever, Unspecified
( ) R06.00 Dyspnea, Unspecified
( ) J02.9 Acute Pharyngitis
( ) J01.90 Acute Sinusitus, Unspecified
( ) J00 Acute Nasopharyngitis
( ) J32.9 Unspecified Sinusitus, Chronic
( ) R09.3 Abnormal Sputum
( ) J03.90 Acute Tonsillitis
( ) R07.81 Pleurodynia
( ) R53.82 Chronic Fatigue, Unspecified
( ) J31.0 Unspecified Rhinitis
( ) R68.83 Chills (without fever)
( ) R06.9 Abnl of breathing, Unspecified
( ) R07.82 Intercostal chest pain
( ) J40 Bronchitis, Unspecified
( ) J44.9 COPD, unspecified
( ) J43.2 Emphysema, Centrilobular
( ) R06.02 Shortness of Breath
( ) R06.01 Orthopnea
( ) J43.9 Emphysema, Unspecified
( ) J06.9 Acute Upper Respiratory Infections of Unspecified Site
( ) R91.1 Pulmonary Nodule, Solitary
( ) R05 Cough
( ) R06.2 Wheezing

ANTIBIOTIC RESISTANCE

( ) Z16.30 Resistance to unspecified antimicrobial drugs
( ) Z16.31 Resistance to antiparasitic drug(s)
( ) Z16.32 Resistance to antifungal drug(s)
( ) Z16.33 Resistance to antiviral drug(s)
( ) Z16.35 Resistance to multiple antimicrobial drugs
( ) Z16.39 Resistance to other specified antimicrobial drugs
( ) Z16.341 Resistance to single antimycobacterial drug
( ) Z16.342 Resistance to multiple antimycobacterial drugs

PATIENT ACKNOWLEDGMENT AND IRREVOCABLE ASSIGNMENT OF BENEFITS

The information provided on this form and on the label affixed to the specimen cup is accurate. The specimen identified on this form is my own. I have not adulterated it in any way. I am voluntarily submitting this specimen for analysis by my healthcare provider and/or third party lab. I authorize the lab to release the results of this test to the ordering healthcare provider. The lab is authorized to bill my insurance provider, or any payer, whether fully insured or self-insured, and I will irrevocably assign any payment of benefits, claims, rights, and interests related to the services my healthcare provider performed against any payer. I further authorize the lab and my healthcare provider to release to my insurance provider any medical information necessary to process this claim.

I acknowledge that AIM Laboratories may be an out-of-network facility/provider with my insurance provider. I am also aware that in some circumstances my insurance provider may send the payment directly to me. I agree to endorse the insurance check and forward it to AIM Laboratories within 15 days of receipt as payment towards the lab services provided by AIM. I acknowledge that I am responsible for any amounts =not covered by my insurer including any deductibles and co-payments/co-insurance. I understand that AIM Laboratories may use my specimen and any testing performed on that specimen for research and development so long as the information has been de-identified pursuant to law. I am aware that all AIM Laboratories Privacy Practices can be found at www.aimlaboratories.com.