GeneStreet Laboratories

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Respiratory Pathogen Detection Test Requisition

1. PATIENT INFORMATION (REQUIRED)

Please attach a copy of patient demographic sheet

First Name_____ Last Name_____
DOB (mm/dd/yyyy) _____ ☐ Male ☐ Female Age_____
Address_____
City_____ State_____ Zip Code _____
Phone _____ Email_____

3. ORDERING PHYSICIAN INFORMATION (REQUIRED)

First Name_____ Last Name_____
Medical Credentials_____ NPI#_____
Facility Name_____
Address_____
City_____ State_____ Zip_____
Telephone: _____

2. PATIENT PAYMENT OPTIONS

☐ **INSURANCE: Please attach a copy of front and back of insurance card**

☐ **SELF-PAY:** Gene Street Laboratories will contact patient to obtain payment

☐ **CLIENT BILL OR INSTITUTION BILL**

4. SPECIMEN INFORMATION (REQUIRED)

Date of Collection_____ **Collected By**_____

Specimen Type ☐ NASOPHARYNGEAL ☐ OROPHARYNGEAL

☐ SALIVA **(RPP cannot be run on saliva. Saliva is for Covid only)**

5. TEST REQUESTED

☐ **COVID-19** SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV 2) Spike glycoprotein (S protein), Nucleocapsid Protein (N-Protein), ORF1ab
Molecular Testing by PCR

☐ **RESPIRATORY INFECTIOUS DISEASE PATHOGENS (checking this box includes the 20 pathogens listed below)**

☐ Adenovirus 1	☐ Influenza A/H1-2009
☐ Adenovirus 2	☐ Influenza A/H3
☐ Chlamydophila pneumoniae	☐ Influenza B
☐ Coronavirus 229E	☐ Mycoplasma pneumoniae
☐ Coronavirus NL63	☐ Parainfluenza virus type 1
☐ Coronavirus OC43	☐ Parainfluenza virus type 2
☐ Coronavirus HKU1	☐ Parainfluenza virus type 3
☐ Human Enterovirus (pan assay)	☐ Parainfluenza virus type 4
☐ Human Metapneumovirus (hMPV)	☐ Respiratory Syncytial Virus A (RSVA)
☐ Influenza A	☐ Respiratory Syncytial Virus B (RSVB)

ADDITIONAL ICD10 CODES

☐ Z03.818 Suspected Exposure to COVID-19
☐ Z20.828 Known Exposure to COVID-19
☐ R05 Cough
☐ R06.02 Shortness of Breath
☐ R50.9 Fever, Unspecified
☐ J01.90 Acute Sinusitis, Unspecified
☐ J02.9 Acute Pharyngitis, Unspecified
☐ J06.9 Acute Upper Respiratory Infection, Unspecified
☐ J18.9 Pneumonia, Unspecified Organism
☐ J20.9 Acute Bronchitis, Unspecified
☐ J32.9 Chronic Sinusitis, Unspecified
☐ J12.89 Pneumonia, Other Viral Pneumonia
☐ B97.29 Pneumonia, Other Coronavirus
☐ J22: Acute Lower Respiratory Infection, Unspecified
☐ B97.29 Pneumonia, Other Coronavirus
☐ J20.8 Acute Bronchitis, Unspecified
☐ B97.29 Pneumonia, Other Coronavirus
☐ J40 Bronchitis, Unspecified
☐ B97.29 Pneumonia, Other Coronavirus

☐ **Antibiotic Resistance Reflex Testing (ABR testing is only performed if a pathogen is detected in the Infectious Disease Panel ordered)**

VanA, VanB (Vancomycin genes)	SHV, KPC Groups	tet B, tet M (Tetracycline genes)	ACT, MIR, FOX, ACC Groups
ermB, C; mefA	dfr (A1, A5), sul (1, 2) probes	IMP, NDM, VIM Groups	OXA-48,-51 (Class D oxacillinase)
PER-1/VEB-1/GES-1 Groups	mecA (Methicillin gene)	qnrA1, qnrA2, qnrB2	CTX-M1 (15), M2 (2), M9 (9), M8/25 Groups

8. PATIENT INFORMED CONSENT

By signing below, I, the patient, confirm that I have been informed about the details of the test(s) ordered for me by my provider. I have read the informed consent and I give permission to GeneStreet to perform laboratory testing as described. I understand the risks, benefits and limitations of testing and I voluntarily consent to testing. I authorize GeneStreet to act as my Authorized Representative in requesting a prior authorization, appeal or documents from my health insurance carrier regarding the above-noted service or proposed service and to inform my health plan of my test result only if required for preauthorization or payment of test(s) ordered or additional reflex testing. I understand that I am responsible for all co-pays, deductibles, and amounts not covered by my insurance. I also authorize the release of my medical information necessary to process this claim. I understand that genetic testing not performed by this laboratory will be forwarded to another accredited reference laboratory. I understand and agree that my leftover specimen and clinical information may be used, without information directly identifying me, for research, education, and other business purposes of GeneStreet (each a "secondary use" and together "secondary uses"). I understand that this may involve GeneStreet sharing my leftover specimen and clinical information with other third parties. My leftover specimen and clinical information will be assigned a unique code before any secondary uses. My name or other personal identifying information will not be used in or linked to my specimen and clinical information when they are shared with third parties unless I explicitly authorize that disclosure. I understand that GeneStreet, itself or through its contractors on its behalf, may contact me at a later date regarding my interest in participating in other research activities, including contributing additional clinical information or specimens for use in such activities and/or authorizing the use of my identifiable information for secondary uses. I understand and agree that this authorization and consent is voluntary. More information is available at www.genestreet.com/policies/privacy-policy. This specimen was provided voluntarily for analysis and I authorize GeneStreet to process, bill and provide results. I authorize that payment(s) be made on my behalf to GeneStreet for any services provided to me by GeneStreet. I understand that genetic testing not performed by this laboratory will be forwarded to another accredited reference laboratory.

Patient Signature: _____ **Date:** _____

9. CONFIRMATION OF INFORMED CONSENT AND MEDICAL NECESSITY

I attest that the patient has received and read the GeneStreet Informed Consent document, or has had it read to him or her, and that I have fully informed the patient about the purpose, capabilities, and limitations of the ordered test. The patient has voluntarily given his or her full consent for the ordered test and a signed copy of this consent is available on file. Any GeneStreet Informed Consent that the patient agrees to at a later date will supersede and replace this Informed Consent.

STATEMENT OF MEDICAL NECESSITY

By signing below, I, the ordering Medical Provider, confirm that testing is medically necessary and that test results may impact medical management for the patient.

Ordering Physician Signature _____ **Date** _____