PRECISION DIAGNOSTICS

TEL: 337-706-8230
FAX: 337-706-8240

LABORATORY REQUISITION

PATIENT DEMOGRAPHICS

Last | First

SS# | Sex | DOB

Address

City | State | Zip | Parish

Home Phone | Work Phone

Race: ☐ White ☐ African American / Black ☐ Native American ☐ Asia / Pacific Islander ☐ Other / Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private ☐ Self Pay ☐ Client Bill

Policy #:

Insurance Co. Name / Address

Insured Name

Relationship to Insured

Date and Time of Collection:

Source:

Pregnant: ☐ Yes ☐ No

Is This Test for? ☐ Diagnosis ☐ Surveillance

Is This Patient Symptomatic? ☐ Yes ☐ No ☐ Unknown

If so, Date of Symptoms Onset: _____

Symptoms/Diagnosis/ICD-10 Codes:

Submitter / Provider Name:

Provider Address:

Provider Zip Code

Provider NPI

Provider Phone | Provider Fax

UPPER RESPIRATORY

☐ **RESPIRATORY PANEL** BioFire– Includes SARS-CoV-2 (nasopharyngeal swab in UTM/VTM)

VIRUSES

Adenovirus
Coronavirus 229E
Coronavirus HKU1
Coronavirus NL 63
Coronavirus OC43
SARS-CoV-2
Human Metapneumovirus
Human Rhinovirus/Enterovirus
Influenza A
Influenza A/H1
Influenza A/H3
Influenza A/H1-2009
Influenza B
Parainfluenza Virus 1
Parainfluenza Virus 2
Parainfluenza Virus 3
Parainfluenza Virus 4
Respiratory Syncytial Virus

BACTERIA

Bordetella pertussis
Bordetella parapertussis
Chlamydia (Chalmydophila) pneumoniae
Mycoplasma pneumoniae

☐ **COVID - if Negative Result Reflex to BioFire Respiratory Panel** (UTM/VTM)
SARS CoV-2

☐ **COVID ONLY** (UTM/VTM)
SARS CoV-2

GASTROINTESTINAL

☐ **GASTROINTESTINAL PANEL** (BioFire - Copan Fecal Swab/Stool in Cary Blair Transport Media)

BACTERIA

Campylobacter (jejuni, coli, and upsaliensis)
Clostridium (Clostridium) difficile (toxin A/B)
Plesiomonas shigelloides
Salmonella
Vibrio (parahaemolyticus, vulnificus, & cholerae)
  Vibrio cholerae
Yersinia enterocolitica
Diarrheagenic E.coli/Shigella
  Enteroaggregative E.coli (EAEC)
  Enteropathogenic E.coli (EPEC)
  Entertoxigenic E.coli (ETEC) lt/st
  Shiga-like toxin-producing E.coli (STEC) stx1/stx2 E.coli 0157
Shigella/Enteroinvasive E.coli (EIEC)

VIRUSES

Adenovirus F 40/41
Astrovirus
Norovirus GI/GII
Rotovirus A
Sapovirus (I, II, IV, and V)

PARASITES

Cryptosporidium
Cyclospora cayetanensis
Entamoeba histolytica
Giardia lamblia

UTI

☐ **UA/UC**

☐ **UC**

ALLERGY TESTING (1 mL blood draw)

☐ **Environmental Testing Panel**

☐ **Food Allergy Panel**

STI

☐ **CT/GC/TV PANEL** (BD Max UVE swab or urine)
- Chlamydia trachomatis
- Neisseria gonorrhoeae
- Trichomonas vaginalis

☐ **Bacterial Vaginosis Panel** (BD Max UVE swab)

Candida group
  C. albicans
  C. dubliniensis
  C. parapsilosis
  C. tropicalis
Candida glabrata
Candida krusei

Lactobacillus spp.
  L. crispatus
  L. jensenii
Gardnerella vaginalis
Atopobium vaginae
BVAB-2
Megasphaera-1
Trichomonas vaginalis

☐ **HPV** (ThinPrep only)
HPV High Risk 16,18,31,33,35,39,45,51,52,56,58, 59,66,68
- Positive HPV reflex to Genotypes 16,18,45

☐ **HSV 1 / 2** (AG Universal Swab)

Comments: _____

Provider's Signature* _____

Date* _____

***Provider Signature Attestation:** I am a licensed medical professional. I acknowledge that the test requested herein is medically necessary and the patient is eligible for the test. I attest that the documentation of medical necessity for tests ordered is documented in the patient's medical record, which will be made available upon request of performing laboratory and/or third-party payer. Tests not ordered by the physician who is treating the beneficiary are not reimbursable. **Note:** Medicare does not generally cover routine tests.