GI REQUISITION

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PLEASE ATTACH: COPY OF INSURANCE CARD (FRONT/BACK) AND DEMOGRAPHIC SHEET
Missing Information May Delay Turn-Around-Time and Reporting of Results.

1 PATIENT INFORMATION

Collection Date:

Facility name (if applicable)		Attach Facesheet of patient info
Patient Name (Last)	(First)	(Middle)
Date of Birth	Race	Ethnicity
Social Security Number		Gender
Address		
City	State Zip	Phone

3 INSURANCE INFORMATION

Clearly mark all mandatory billing sections

Is this patient a SKILLED (Medicare A) patient? ☐ YES ☐ NO

Primary Insurance	Policy #	Group#
Person Insured	Self/Spouse	DOB of Insured
Secondary Insurance	Policy #	Group#
Person Insured	Self/Spouse	DOB of Insured
Prior Authorization #		

2 PROVIDER INFORMATION

Practice Name			
Address			
City		State	Zip
Phone	Zip	Fax	
Physician Name			NPI #

Are you a mobile provider ☐ YES ☐ NO If yes, fill out section #1 in its entirety.
Does patient live in ☐ Residential Home ☐ LTC

4 BILLING INFORMATION

Please bill my credit card: ☐ AMEX ☐ MasterCard ☐ Visa ☐ Discover

Name as it appears on card:

Account #:

Expiration Date: CVC:

Amount: Date:

I have been notified of the test cost and understand that my credit card will be charged the full amount for the testing. Patient Signature Section, please add "Patient signature is required for patients with TRICARE insurance.

Patient/Guardian Signature:

TEST SELECTION CHECK APPLICABLE BOXES

Sample Type / Location:

ALLERGIES:

Renal FXN: ☐ NML ☐ ABNL Hepatic FXN: ☐ NML ☐ ABNL

CLINICAL NOTES:

☐ GI PANEL - ORGANISM TESTED WITH ABR

Check this box for testing entire panel

- ☐ Aeromonas hydrophila
- ☐ Blastocystis/Blastocystis hominis
- ☐ Campylobacter jejuni
- ☐ Campylobacter upsaliensis
- ☐ Campylobacter coli
- ☐ Chlamydia trachomatis
- ☐ Clostridium difficile
- ☐ Clostridium perfringens (CPE, alpha)
- ☐ Clostridioides difficile Toxin A/B
- ☐ Cryptosporidium spp.
- ☐ Cyclospora cayetanensis
- ☐ Dientamoeba fragilis
- ☐ E. coli O157
- ☐ Entamoeba histolytica
- ☐ Enteroaggregative E. coli (EAEC)
- ☐ Enterohemorrhagic E. coli (EHEC)
- ☐ Enteropathogenic E. coli (EPEC)
- ☐ Enterotoxigenic E. coli (ETEC)
- ☐ Giardia lamblia
- ☐ Giardia intestinalis
- ☐ Hypervirulent C. difficile O27 (CD hyper)
- ☐ Shigella/Enteroinvasive E. coli (EIEC)
- ☐ Shiga toxin producing E. coli (STEC)
- ☐ Verotoxin positive E. coli
- ☐ Helicobacter pylori
- ☐ Plesiomonas shigelloides
- ☐ Pseudomonas aeruginosa
- ☐ Salmonella spp.
- ☐ Salmonella enterica
- ☐ Shigella spp.
- ☐ Staphylococcal enterotoxins A, B
- ☐ Staphylococcus aureus
- ☐ Vibrio cholerae
- ☐ Vibrio parahaemolyticus
- ☐ Vibrio vulnificus
- ☐ Yersinia enterocolitica
- ☐ Adenovirus (Intestinal)
- ☐ Astrovirus
- ☐ Enterovirus (pan) A,B,C,D68
- ☐ Norovirus GI/GII
- ☐ Rotavirus A
- ☐ Rotavirus C
- ☐ Sapovirus

ANTIBIOTIC RESISTANCE GENES

These are automatically tested in Reflex ABX – only when positives are detected.

Aminoglycoside Resistance
AmpC beta lactamase ACT/MIR, FOX, ACC Groups
Class A beta lactamase CTX-M1 (15), M2 (2), M9 (9), M8/25
Class A beta lactamase SHV, KPC Groups
Class B metallo beta lactamase IMP, NDM, VIM Groups
Class D oxacillinase OXA-48, -51
Extended Spectrum Betalactamases Resistance Gene TEM G236S
Fluroquinolone Resistance Genes qnrA1, qnrA2, qnrB(qnrS)
Macrolide Lincosamide Streptogramin Resistance ermB, ermC, ermA
Methicillin Resistance Gene mecA
Tetracycline Resistance Gens tetB, tetM
Trimethoprim/Sulfamethoxazole Resistance dfr(A1,A5), sul(1,2)
Vancomycin Resistance Genes VanA, VanB

☒ PHARM D GUIDANCE

PhD Pharmacist driven interpretation of your patient's specific infection and anibiotic resistance markers for effective antibiotic recommendations consistent with Antibiotic Stewarship.

MEDICAL NECESSITY MUST BE COMPLETED

ICDs Listed for Convenience Only - Please document applicable ICD-10 Codes.

- ☐ K10.9 Unspecified abdominal pain
- ☐ K29.70 Gastritis, Unspec. w/o Bleeding
- ☐ K29.9 Gastroduodenitis, Unspecified
- ☐ K30 Functional Dyspepsia
- ☐ K51.90 Unspecified Ulcerative Colitis
- ☐ K51.90 Noninfective gastroenteritis and colitis, unspecified
- ☐ K52.89 Other specified noninfective gastroenteritis and colitis
- ☐ K57.30 Diverticulosis of Colon (w/o mention of hemorrhage)
- ☐ K58.9 Irritable Bowel Syndrome
- ☐ K59.1 Functional diarrhea
- K85.9 Acute Pancreatitis
- ☐ K92.1 Blood in Stool
- ☐ R10.0 Acute abdomen
- ☐ R10.815 Periumbilic abdominal tenderness
- ☐ R10.816 Epigastric abdominal tenderness
- ☐ R10.817 Generalized abdominal tenderness
- ☐ R10.819 Abdominal tenderness, unspecified site
- ☐ R10.84 Abdominal Pain, Generalized
- ☐ R11.10 Vomiting, unspecified
- ☐ R11.2 Nausea with vomiting, unspecified
- R18.0 Malignant ascites
- ☐ R18.8 Other ascites
- ☐ R19.00 Intra-abdominal and pelvic swelling, unspecified
- ☐ R19.05 Periumbilic swelling, mass or lump
- ☐ R19.06 Epigastric swelling, mass or lump
- ☐ R19.07 Generalized intra-abdominal and pelvic swelling
- ☐ R19.09 Other intra-abdominal and pelvic swelling
- ☐ R19.30 Abdominal rigidity, unspecified
- ☐ R19.4 Change in bowel habit
- ☐ R19.5 Other fecal abnormalities
- ☐ R19.7 Diarrhea

Patient Consent

I am voluntarily seeking laboratory service and hereby consent to provide a sample as requested. I have the right to refuse testing, but I understand this may impact my treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the laboratory my right to insurance benefits that may be payable to me for services provided arising from any insurance policy, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of benefits directly to the laboratory. I understand acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I understand that any payment I receive for services rendered by the laboratory from my insurance provider should be forwarded to the laboratory immediately.

Patient Signature: **Date:**

Medical Provider Consent

This test is medically necessary for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. By my signature below, I indicate that I am the referring physician or authorized health care provider. I have explained the purpose of the test. The patient has been given the opportunity to ask questions and/or seek further counsel. The patient has voluntarily decided to have the test performed by Vero Diagnostic Lab. As the medical provider, I am responsible for documenting applicable ICD-10 diagnosis codes.

Medical Provider Signature: **Date:**

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Patient Name:_____

Patient D.O.B. _____