Vero Diagnostic Lab

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TruUTI™
3216 South Alston Avenue, Durham, North Carolina 27713
Phone: 919-341-1256 • Fax: 919-341-1256
CLIA # 34D2131299 • CAP# 8190193
Laboratory Director: Dr. Manoj Tyagi, PhD. NRCC - CC, FAACC/FACB

**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**

**MARKERS:**
☐Pregnant ☐Warfarin ☐Recurrent UTIs ☐Immunocompromised ☐Renal compromised ☐Dialysis ☐Hepatic compromised ☐Catheter

## ☐ UTI PANEL - ORGANISM TESTED WITH ABR

***Check this box for testing entire panel***

**BACTERIUM**
- ☐ Acinetobacter baumannii
- ☐ Chlamydia trachomatis
- ☐ Citrobacter freundii
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Enterococcus faecalis
- ☐ Enterococcus faecium
- ☐ Escherichia coli
- ☐ Klebsiella oxytoca
- ☐ Klebsiella pneumoniae
- ☐ Morganella morganii
- ☐ Mycoplasma genitalium
- ☐ Mycoplasma hominus
- ☐ Neisseria gonorrhoeae
- ☐ Proteus mirabilis
- ☐ Proteus vulgaris
- ☐ Providencia stuartii
- ☐ Pseudomonas aeruginosa
- ☐ Serratia marcescens
- ☐ Staphylococcus aureus
- ☐ Staphylococcus saprophyticus
- ☐ Streptococcus agalactiae
- ☐ Streptococcus pyogenes
- ☐ Treponema pallidum (syphilis)
- ☐ ureaplasma parvum
- ☐ Ureaplasma urealyticum

**FUNGAL**
- ☐ Candida albicans
- ☐ Candida auris
- ☐ Candida glabrata
- ☐ Candida parasilopsis
- ☐ Candida tropicalis

**PARASITIC**
- ☐ Trichomonas vaginalis

## 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.**

- ☐ N30.0 Acute cystitis
- ☐ N30.1 Interstitial cystitis (chronic)
- ☐ N39.0, UTI, site not specified
- ☐ N40.1 BPH w/lower UTI symptoms
- ☐ N97.0-N97.9 Female infertility
- ☐ R21 Rash and other nonsp skin eruption
- ☐ R30.0 Dysuria
- ☐ R30.9 Painful micturition, unspecified
- ☐ R31.0 Gross hematuria
- ☐ R31.29 Other microscopic hematuria
- R35.0 Frequency of micturition
- ☐ R39.15 Urgency of urination
- ☐ R39.9 Unspec. symptoms and signs involving the genitourinary system
- ☐ R50.9 Fever, unspecificed
- ☐ R53.82 Chronic fatigue, unspecified
- ☐ R68.83 Chills (without fever)
- ☐ Z11.3 Encounter for screening for infections with a predominantly sexual infections with a predominantly sexual mode of transmission
- ☐ Z11.51 Encounter for screening of human papillomavirus (HPV)
- ☐ Z20.2 Exposure to disease that is predominantly sexually transmitted
- ☐ Z79.899 Other long-term (current) drug therapy
- ☐ _____
- ☐ _____
- ☐ _____

**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. _____