QDxPathology SERVICES

UTI
U0000016404
CLIA ID# 31D2026917

PATIENT INFORMATION - ALL REQUIRED

Date of Collection: ____________________ Time of Collection: ____________________
Last Name: ____________________ First Name: ______________ MI: _____
Cell #: ____________________ Email: ____________________
Home #: ____________________ Street Address: ____________________
Apt: ____________ City: ____________________ State: __________
Zip: ____________ DOB: (MM/DD/YYYY): ______ / ______ / ____________
Clinical History/Known Drug Allergy: ____________________ ☐ Pregnant

Gender Identity and Sexual Orientation

- ☐ Male
- ☐ Female
- ☐ Non-Binary/Genderqueer
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay or Homosexual
- ☐ Bisexual
- ☐ Other: ____________

Race and Ethnicity - Select all that apply

- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Choose not to disclose
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other: ____________

Guidelines for patient demographics are provided by NJDOH/CLIS (NJSA 45:9-42.46 to -42.49)

REFERRING PHYSICIAN INFO. (Required)

INSURANCE INFO. (Required)

Policyholder Name: ____________________
Insurance Name: ____________________
Policy #: ____________________
Group #: ____________________

Please provide a copy of the front & back of insurance card(s).

- ☐ Bill Insurance
- ☐ Bill Client
- ☐ Self Pay

SPECIMEN ID:

16865 Rev E

LAB ACCESSION #:

____

CC REPORT

Practice/Surgery Center: ____________________
Street Address: ____________________
City: ______________ State: ______ Zip: ________

URINARY TRACT INFECTION PATHOGEN PANEL (26 Targets)

☐ COMPLETE PANEL

BACTERIA

Acinetobacter baumannii	Klebsiella oxytoca	Providencia stuartii
Citrobacter freundii	Klebsiella pneumoniae	Staphylococcus aureus
Enterobacter aerogenes	Morganella morganii	Staphylococcus saprophyticus
Enterobacter cloacae	Mycoplasma genitalium	Streptococcus agalactiae
Enterococcus faecalis	Proteus mirabilis	Streptococcus pyogenes
Enterococcus faecium	Proteus vulgaris	Ureaplasma urealyticum
Escherichia coli	Pseudomonas aeruginosa	Urealpasma parvum

YEAST

Candida albicans
Candida glabrata

STI

Chlamydia trachomatis
Neisseria gonorrhoeae
Trichomonas vaginalis

☐ PANEL WITHOUT STI

ANTIBIOTIC RESISTANCE GENES

ampC	ermC	QnrS	vanC1
blaOXA-48	KPC	tetM	SULL
ermA	mecA	vanA2	DFRA
ermB	QnrA	vanB	

Please see the reverse side for Antibiotic Resistance Gene Correlation.

STATEMENT OF MEDICAL NECESSITY (REQUIRED FOR TESTING)

Must check off at least one essential ICD-10 Code. Test will not be process w/o properly marked Statement of Medical Necessity:

- ☐ **N30.00** Acute cystitis without hematuria
- ☐ **N30.01** Acute cystitis with hematuria
- ☐ **N39.0** Urinary tract infection, site not specified
- ☐ **R30.0** Dysuria
- ☐ **R31.0** Gross hematuria
- ☐ **R35.0** Frequency of micturition
- ☐ **R39.15** Urgency of Urination
- ☐ **R82.90** Unspecified abnormal findings in urine
- ☐ **Z87.440** Personal history of urinary (tract) infections

Additional Primary ICD-10 Codes:

- ☐ **N30.10** Interstitial cystitis (chronic) without hematuria
- ☐ **N30.11** Interstitial cystitis (chronic) with hematuria
- ☐ **N41.1** Chronic prostatitis
- ☐ **R30.9** Painful micturition, unspecified
- ☐ **R31.9** Hematuria, unspecified
- ☐ **R35.1** Nocturia
- ☐ **R39.9** Unspecified symptoms and signs involving the genitourinary system
- ☐ **Z11.51** Encounter for screening for human papillomavirus (HPV)
- ☐ **Z16.30** Resistance to unspecified antimicobial drugs
- ☐ **Z20.2** Contact with and (suspected) exposure to infections with prdominantly sexual mode of transmission
- ☐ **Other:** ____________________

BOTH PATIENT AND PHYSICIAN MUST SIGN to approve testing

By signing below, I confirm I have read the ABN on the reverse side.

Patient Signature: ____________________

I authorize the release of medical information related to services provided herein to my health plan/ insurance carrier and authorize payment directly to QDx Pathology Services and/or lab services provider. I assume responsibility for payment of charges not covered by my healthcare insurer.

Physician Signature: ____________________

CMS requires physician signature on all requisitions. QDx Pathology Services is responsible for verifying signature prior to performing testing.

300 Columbus Circle, Suite A, Edison, NJ 08837 | Tel: (866) 909-PATH | Fax: (908) 272-1478 | www.qdxpath.com

PEEL LABEL HERE ▼ PEEL LABEL HERE ▼ PEEL LABEL HERE ▼ PEEL LABEL HERE ▼

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16865 Rev E
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Cell Number: __________
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QDxPathology SERVICES

*Antibiotic Resistance Gene Correlation

Gene Detected	Class of Antibiotics	Example of Antibiotics
AmpC	Cephalosporins	Cephalexin, cefdinir, cefazolin, cefixime, ceftriaxone, cefoxitin
blaOXA-48, KPC	Carbapenems	Meropenem, ertapenem, imipenem
ermA, ermB, ermC	Macrolides and lincosamide	Erythromycin, azithromycin,clindamycin
mecA	Methicillin	Methicillin, oxacillin, cephalexin, efazolin
QnrA, QnrS	Fluoroquinolones	Levofloxacin, ciprofloxacin, delafloxacin moxifloxacin
vanA, vanB, vanC	Glycopeptide	Vancomycin
SULL, DFRA	Sulfamethoxazole/ trimethoprim	Bactrim
tetM	Tetracycline	Minocycline, doxycycline

Notifier:____________________________________ Date: _______________

Patient Name:____

ADVANCED BENEFICIARY NOTICE OF PAYMENT (ABN):

NOTE: This is to notify you that your healthcare provider has good reason to think you need this/the test(s).

WHAT YOU NEED TO DO NOW

- ▶ Read this notice so you can make an informed decision about your care.
- ▶ Ask us any questions that you may have after you finish reading.
- ▶ Check the box below if you would like to receive the item(s) listed in **TYPE OF TEST** section.

☐ **I WANT THE TEST(S) ORDERED BY MY PHYSICIAN/PROVIDER**

QDx Pathology Services will bill your insurance.

▶ **Signing below means that you have received and understand this notice.**

Signature: ____________________________ Date: ________________

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