INFECTIOUS DISEASE TEST REQUISITION

FAILURE TO COMPLETE ALL FIELDS MAY DELAY PATIENT RESULTS.

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My DNA My Medicine

Physician Information

Practice Name, Provider(s) Name, Office:

Sample Information

Collection Date & Time:

Requisition Completed By:

for iGenomeDx use

Sample Collected By:

Accession Number:

for iGenomeDx use

Ordering Physician/Authorizing Medical Professional Signature: I hereby authorize testing for this patient. I have provided information regarding molecular testing, and the patient has given consent for testing to be performed. I attest that the ICD-10 Diagnosis Codes provided are accurate records and supported by patients records. I attest that these tests are medically necessary. I hereby authorize iGenomeDx Laboratories to send these patient's test results to the patient's third party payer, if needed, to appeal a denial of reimbursement prior to attempts to obtain reimbursement without the release of patient's results.

PROVIDER'S SIGNATURE

Patient Information

Patient Last Name

Patient First, Middle Name

Date of Birth: (MM/DD/YYYY)

Patient Phone

Patient Gender

☐ Female
☐ Male
☐ Undisclosed

Patient Race

☐ White
☐ Black/African American
☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Undisclosed

Patient Ethnicity

☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Undisclosed

Patient Address

City, ST Zip

Patient Email:

I authorize iGenomeDx to analyze the specimen provided by me and report the results of such analysis to the ordering physician in conformance with his/her order

PATIENT'S SIGNATURE

Diagnosis (ICD-10 Codes)

Please state why this test constitutes medical necessity for the patient. Reimbursement requires all diagnoses to be coded to a higher degree of specificity.

Specimen Type

☐ Nasopharyngeal Swab
☐ Wound Swab
☐ Nail Clipping
☐ Fecal Swab
☐ Vaginal Swab
☐ Urine

Billing Information

A photocopy of both sides of Patient's insurance card(s) must be included

☐ Medicare
☐ Medicaid
☐ Commercial
☐ Facility Billed

For the patient paid test's facility is advised to collect payment before specimen collection

Insurance	Primary Insurance	Secondary Insurance
Insurance Company Name		
Member ID		
Group Number		
Patient Relationship to Insured		
Claims Address:		
City/State/Zip		

RESPIRATORY

(Performed with nasopharyngeal E-swab)

VIRUS TARGETS

☐ **SARS-CoV-2 (COVID-19)**

☐ **Influenza**
- ☐ Influenza (A, H1-2009)
- ☐ Influenza B
- ☐ Influenza C
- ☐ Parainfluenza (1, 2, 3 & 4)

☐ **Common Cold**
- ☐ Adenovirus
- ☐ Human bocavirus
- ☐ Human rhinovirus
- ☐ Human coronavirus (NL63/229E/OC43/HKU1)
- ☐ Enterovirus
- ☐ Human parechovirus

☐ **Respiratory Syncytial viruses A/B**

☐ **Metapneumovirus A/B**

BACTERIA TARGETS

☐ **Pneumonia**
- ☐ *Chlamydia pneumoniae*
- ☐ *Mycoplasma pneumoniae*
- ☐ *Staphylococcus aureus*
- ☐ *Streptococcus pneumoniae*
- ☐ *Haemophilus influenzae/Type B*
- ☐ *Klebsiella pneumoniae*
- ☐ *Legionella pneumophila/ longbeachae*

☐ ***Moraxella catarrhalis***

☐ **Whooping Cough**
- ☐ Bordetella sp. (except *B. parapertusis*)

FUNGAL TARGET

☐ *Pneumocystis jirovecii*

For additional respiratory pathogen testing (besides COIVD-19 only), providers must include evidence of **Medical Necessity** in the form of following documents:
- Daily treatment or progress notes
- Record of the providers findings
- Record of the treating providers preliminary & final diagnosis
- Records of the patient's primary complaint

GASTRO

(Performed with Fecal Swab)

VIRUS TARGETS
- ☐ Adenovirus
- ☐ Astrovirus
- ☐ Norovirus G1
- ☐ Norovirus G2
- ☐ Rotavirus
- ☐ Sapovirus

BACTERIA TARGETS
- ☐ Campylobacter sp.
- ☐ *Clostridium difficile*
- ☐ Salmonella sp.
- ☐ Shigella sp.
- ☐ Verotoxin positive *E. coli*
- ☐ *Yersinia enterocolitica*

PARASITES
- ☐ Cryptosporidium sp.
- ☐ Entamoeba histolytica
- ☐ Giardia lamblia

UTI

(Performed with Urine)
- ☐ *Escherichia coli*
- ☐ *Staphylococcus aureus*
- ☐ *Streptococcus saprophyticus*
- ☐ *Enterococcus faecalis*
- ☐ *Ureaplasma urealyticum*
- ☐ Candida sp.
- ☐ *Proteus mirabilis*
- ☐ *Klebsiella pnuemoniae*
- ☐ *Morganella morganii*
- ☐ *Serratia marcescens*
- ☐ *Mycoplasma hominis*
- ☐ *Klebsiella oxytoca*
- ☐ *Enterobacter cloacae*
- ☐ *Providencia stuartii*
- ☐ *Pseudomonas aeruginosa*
- ☐ *Streptococcus agalactiae*

☐ **Resistance Markers**

Wound

(Performed with Wound E-swab)
- ☐ *Acinetobacter baumannii*
- ☐ *Bacteroides spp*
- ☐ *Citrobacter freundii*
- ☐ *Enterobacter aerogenes*
- ☐ *Enterobacter cloacae*
- ☐ *Enterococcus faecalis*
- ☐ *Streptococcus pyogenes*
- ☐ *Enterococcus faecium*
- ☐ *Escherichia coli*
- ☐ *Klebsiella oxytoca*
- ☐ *Klebsiella pneumoniae*
- ☐ *Morganella morganii*
- ☐ *Proteus mirabilis*
- ☐ *Proteus vulgaris*
- ☐ *Pseudomonas aeruginosa*
- ☐ *Staphylococcus aureus*
- ☐ *Clostridium novy*
- ☐ *Clostridium septicum*
- ☐ *Clostridium perfringens*
- ☐ *Kingella kingae*

☐ **Resistance Markers**

ONYCHOMYCOSIS

(Performed with Nail Clipping)
- ☐ *Acremonium strictum*
- ☐ *Alternaria*
- ☐ *Aspergillus niger*
- ☐ *Aspergillus terreus*
- ☐ *Candida albicans*
- ☐ *Candida glabrata*
- ☐ *Candida krusei*
- ☐ *Candida lusitaniae*
- ☐ *Candida parapsilosis*
- ☐ *Candida tropicalis*
- ☐ *Epidermophyton floccosum*
- ☐ *Fusarium solani*
- ☐ *Microsporum audouinii*
- ☐ *Microsporum canis*
- ☐ *Neofusicoccum mangiferae*
- ☐ *Trichophyton interdigitale*
- ☐ *Trichophyton rubrum*

STI – swab

(Performed with Vaginal E-Swab or Urethral E-swab)
- ☐ *Chlamydia trachomatis*
- ☐ *Gardnerella vaginalis*
- ☐ *Mycoplasma genitalium*
- ☐ *Neisseria gonorrhoeae*
- ☐ *Treponema pallidum*
- ☐ *Trichomonas vaginalis*
- ☐ Herpes simplex virus 1
- ☐ Herpes simplex virus 2
- ☐ *Ureaplasma parvum / urealyticum*

STI-urine

(Performed with Urine)
- ☐ *Chlamydia trachomatis*
- ☐ *Gardnerella vaginalis*
- ☐ *Mycoplasma genitalium*
- ☐ *Neisseria gonorrhoeae*
- ☐ *Trichomonas vaginalis*
- ☐ *Ureaplasma parvum / urealyticum*

Helicobacter pylori

(Performed with Fecal Swab)
- ❑ *Helicobacter pylori*

Strep differentiation

- ❑ Group A Strep
- ❑ Group B strep
- ❑ Group C&G Strep

MRSA

(*Methicillin resistant Staphylococcus aureus)*

- ❑ *Staphylococcus aureus*
- ❑ mecA

Informed Consent Information

Submission of a requisition for any test listed on this iGenomeDx Requisition form constitutes acknowledgement by the ordering Physician and Patient:

1. This Ordering physician has obtained written informed consent for each test ordered, as required by applicable state and federal laws. A copy of the informed consent is not required by iGenomeDx in order to process a sample, but a copy must be available in the ordering physician's record.
2. The patient has provided written authorization for iGenomeDx to report the results of each test directly to the ordering physician.
3. DNA testing usually provides precise information, however, several sources of error are possible. These include, but are not limited to, clinical misdiagnosis of the condition, and sample misidentification.
4. De-identified samples and data may be used for validation or research and development.
5. All test results will be released directly to the ordering physician, or on their behalf, as state and local laws allow.
6. iGenomeDx is authorized to perform high complexity testing under the Clinical Laboratory Improvement Amendments (CLIA). The results are not intended to be used as the sole means for clinical diagnosis or patient care decisions.
7. The Patient acknowledges their right to obtain a copy of their written report as required by state and federal laws.

Patient Signature:_____ Date:_____