CABOT LAB INFECTIOUS DISEASE REQUISITION FORM

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Ordering Providers / NPI#	Provider Information	Affix Accession Label
☐ _____	☐ _____	
☐ _____	☐ _____	
☐ _____	☐ _____	
☐ _____	☐ _____	

A PATIENT INFORMATION - PLEASE PRINT LEGIBLY — ALL FIELDS REQUIRED

First Name: _____ Last Name: _____ MI: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Phone: _____

Date of Birth: _____ Race: _____ Ethnicity: _____ Gender: ☐ Male ☐ Female

Sample Date of Collection: _____ **Sample Collector Initials:** _____

IN ADDITION TO WRITING PATIENT INFORMATION, PLEASE ATTACH A COPY OF THE PATIENT'S FACE SHEET / DEMOGRAPHICS

B BILLING INFORMATION — REQUIRED

ATTACH A COPY OF THE PATIENT'S **INSURANCE CARD** AND **DRIVERS LICENSE** (FRONT AND BACK)

Select Box: ☐ Patient/Self-pay ☐ Client ☐ Insurance

ICD-10 Diagnosis Code

For Insurance Only:

Insured Name: _____ DOB: _____

Primary Insurance: _____ Subscriber ID: _____

Secondary Insurance: _____ Subscriber ID: _____

C INFECTIOUS DISEASE TEST ORDERS (Select syndromic menu as medically necessary for the treatment and/or diagnosis of the individual patient)

☐ GASTROINTESTINAL*

SAMPLE TYPE: ☐ Rectal Swab ☐ Stool Swab ☐ Other _____

Bacterial
Adenovirus HAdV-F, HAdV-G Astrovirus;
Sapovirus G1, G2 Campylobacter jejuni,
coli
Clostridioides difficile (toxins A, B)
Enteroaggregative E. coli (EAEC)
Enteroinvasive E. coli (EIEC) / Shigella spp
Enteropathogenic E. coli (EPEC)
Enterotoxigenic E. coli (ETEC)
Listeria monocytogenes Norovirus
(Genogroup 1, 2) Rotavirus A, B
Salmonella enterica
Shiga toxin-producing E. coli (STEC)
Shiga toxin-producing E. coli 0157
(STEC 0157)
Vibrio cholerae, parahaemolyticus,
vulnificus
Yersinia enterocolitica
Microsporidium (Enterocytozoon bieneusi,
Encephalitozoon intestinalis)

Ova and Parasite
Cryptosporidium felis, hominis, parvum
Cyclospora cayetanensis, Cystoisospora belli
Dientamoeba fragilis, Entamoeba histolytica
Giardia duodenalis (lamblia) Microsporidium
(Enterocytozoon bieneusi,
Encephalitozoon intestinalis)

Antibiotic Resistance Genes (listed below)

Add-on Only - Select for add-on testing: ☐Candida albicans, parapsilosis, tropicalis ☐Candida glabrata ☐Candida krusei ☐Chlamydia trachomatis ☐Neisseria gonorrhoeae ☐Trichomonas vaginalis

☐ NAIL/PARONYCHIA, HAIR*

SAMPLE TYPE: ☐ Fingernail Clipping ☐ Toenail Clipping ☐ Paronychia ☐ Tissue ☐ Hair ☐ Other _____

Bacterial
Bacteroides fragilis, vulgatus
Enterobacter aerogenes, cloacae
Enterococcus faecalis, faecium
Escherichia coli
Klebsiella pneumoniae, oxytoca
Peptostreptococcus anaerobius, asaccharolyticus,
magnus, prevotii
Proteus mirabilis, vulgaris
Pseudomonas aeruginosa
Serratia marcescens
Staphylococcus aureus
Staphylococcus spp[3]
Streptococcus agalactiae[1]
Streptococcus pyogenes[2]

Fungal
Aspergillus flavus, fumigatus, niger, terreus
Blastomyces dermatitidis
Candida albicans, glabrata, parapsilosis, tropicalis
Epidermophyton floccosum
Fusarium oxysporum, solani
Malassezia furfur, restricta, sympodialis, globosa
Microsporum audouinii, canis, gypseum
Trichophyton mentagraphophytes/interdigitale,
rubrum, soudanense, terrestre, tonsurans,
verrucosum, violaceum
Trichosporon mucoides, asahii

Antibiotic Resistance Genes (listed below)

Add-on Only - Select for add-on testing: ☐Candida auris

☐ OTOLARYNGOLOGY INFECTION*

SAMPLE TYPE: ☐ Ear ☐ Swab ☐ Tympanocentesis Fluid ☐ Nasopharynx Swab ☐ Throat Swab ☐ Other _____

Acinetobacter baumannii
Adenovirus
Alternaria spp, Curvularia lunata, Penicillium spp.
Aspergillus flavus, fumigatus, niger, terreus
Bordetella pertussis, parapertussis, bronchiseptica
Candida albicans, glabrata, parapsilosis, tropicalis
Chlamydia trachomatis
Corynebacterium jeikeium, striatum,
tuberculostearicum
Cutibacterium (Propionibacterium) acnes
Cytomegalovirus[18]
Enterobacter aerogenes, cloacae
Enterococcus faecalis, faecium
Enterovirus (pan)
Epstein-Barr virus[19]
Escherichia coli
Fusarium oxysporum, solani
Fusobacterium nucleatum, necrophorum
Haemophilus influenzae
Herpes simplex virus 1, 2[4]
Klebsiella pneumoniae, oxytoca
Moraxella catarrhalis
Neisseria gonorrhoeae
Parainfluenza virus (types 1, 2, 3, 4)
Peptostreptococcus anaerobius, asaccharolyticus,
magnus, prevotii
Proteus mirabilis, vulgaris
Pseudomonas aeruginosa
Rhizopus spp, Mucor spp
Staphylococcus aureus
Staphylococcus spp[3]
Streptococcus agalactiae[1] Streptococcus
anginosus, constellatus,
intermedius[20]
Streptococcus mitis, sanguis, mutans[21]
Streptococcus pneumoniae
Streptococcus pyogenes[2]
Varicella zoster virus[22]

Antibiotic Resistance Genes (listed below)

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☐ **OPHTHALMOLOGY INFECTION***

SAMPLE TYPE: ☐ Eye Swab ☐ Lacrimal Fluid ☐ Corneal Scraping ☐ Vitreous Fluid ☐ Other _____

Acanthamoeba castellani, polyphaga; Vermamoeba (Hartmannella) vermiformis
Acinetobacter baumannii
Adenovirus
Alternaria spp., Curvularia lunata, Penicillium spp
Aspergillus flavus, fumigatus, niger, terreus
Bacillus cereus, thuringiensis
Candida albicans, glabrata, parapsilosis, tropicalis
Chlamydia trachomatis
Citrobacter freundii
Corynebacterium jeikeium, striatum, tuberculostearicum
Cutibacterium (Propionibacterium) acnes
Cytomegalovirus[4]
Demodex folliculorum
Enterobacter aerogenes, cloacae
Enterococcus faecalis, faecium
Enterovirus (pan)
Epstein-Barr virus[19]
Escherichia coli
Fusarium oxysporum, solani
Fusobacterium nucleatum, necrophorum
Haemophilus influenzae
Herpes simplex virus 1, 2
Klebsiella pneumoniae, oxytoca
Microsporidia (Encephalitozoon hellum, cuniculi, Nosema (Vittaforma) ocularum)
Moraxella catarrhalis
Morganella morganii
Mycobacterium spp
Neisseria gonorrhoeae
Peptostreptococcus anaerobius, asaccharolyticus, magnus, prevotii
Proteus mirabilis, vulgaris
Pseudomonas aeruginosa
Rhizopus spp, Mucor spp
Staphylococcus aureus
Staphylococcus spp[3]
Streptococcus agalactiae[1] Streptococcus anginosus, constellatus, intermedius[20]
Streptococcus mitis, sanguis, mutans[21]
Streptococcus pneumoniae
Streptococcus pyogenes[2]
Toxoplasma gondii
Varicella zoster virus[22]

Antibiotic Resistance Genes (listed below)

Antibiotic Resistance Genes:
VanA, VanB[7]
ermB, C; mefA[8] SHV, KPC Groups[9]
dfr (A1, A5), sul (1, 2)[10] mecA[11]
qnrA1, qnrA2, qnrB2[12] tet B, tet M[13]
IMP, NDM, VIM Groups[14] ACT, MIR, FOX, ACC Groups[15]
OXA-48,-51[16] CTX-M1 (15), M2 (2), M9 (9), M8/25 Groups[9]

1 Group B strep (GBS)
2 Group A strep
3 Coagulase negative species: S.epidermidis, S. haemolyticus, S. lugdunensis, S. saprophyticus
4 HSV-1, HSV-2
5 VZV, Human Herpesvirus 3
6 Syphilis
7 Vancomycin
8 Macrolide Lincosamide Streptogramin
9 Class A Beta-lactamase
10 Trimethoprim/Sulfamethoxazole
11 Methicillin
12 Fluoroquinolone
13 Tetracycline
14 Class B Metallo-beta-lactamase
15 Amp C Beta-lactamase 16 Class D oxacillinase
18 Human Herpesvirus 5, CMV
19 Human Herpesvirus 4, EBV
20 Viridans anginosus group
21 Viridans group
22 Human Herpesvirus 3, VZV

D PATIENT ACKNOWLEDGMENT — REQUIRED

Patient Acknowledgment and Irrevocable Assignment of Benefits: This specimen was provided voluntarily for analysis, and I authorize the CLIA Licensed laboratory service provider and its subsidiaries and designees listed on this requisition (collectively, "the Laboratory") to process, bill any insurance/healthcare coverage on my behalf and provide test results for laboratory services rendered, and I irrevocably assign to and direct that payment be made to the Laboratory. The information provided on this form and on the label affixed to the specimen is accurate. The specimen identified on this form is my own. I have not adulterated it in any way. I am voluntarily submitting this specimen for analysis by my healthcare provider and/or third-party lab. I authorize the lab to release the results of this test to the ordering healthcare provider. The lab is authorized to bill my insurance provider, or any payer, whether fully insured or self-insured, and I will irrevocably assign any payment of benefits, claims, rights, and interests related to the services my healthcare provider performed against any payer. I further authorize the lab and my healthcare provider to release to my insurer any medical information necessary to process this claim.
I acknowledge that Cabot Lab may be an out-of-network facility/provider with my insurer. I am also aware that in some circumstances my insurance provider may send the payment directly to me. I agree to endorse the insurance check and forward it to Cabot Lab within 15 days of receipt as payment towards the lab services provided by the Laboratory. I acknowledge that I am responsible for any amounts not covered by my insurer including any deductibles and co-payments or co-insurance. I understand that the Cabot Lab and/or any CLIA Licensed laboratory may use my specimen and any testing performed on that specimen for research and development so long as the information has been de-identified. I am aware that Cabot Lab Privacy Practices can be found at www.cabotlab.com.

Attestation Of Uninsured Patient and Self-Pay Payment Modes: If I do not have health care coverage such as individual, employer-sponsored, Medicare, or Medicaid coverage or I have requested Self-Pay for laboratory services ordered. Therefore, I understand that I am financially responsible for all the fees incurred and must make payment in advance to receive laboratory services and test results. I affirm, attest, and authorize Cabot Lab to charge the amount listed on Cabot Lab, LLC's website https://cabotlab.com/pay-now to the credit card provided. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement. Your signature below acknowledges your total responsibility in paying for any fees not covered by your insurance company or invalid insurance coverage provided and gives Cabot Lab, LLC permission to charge your credit card for all diagnostic laboratory testing. Your signature acknowledges that these fees will automatically be charged or debited from your card without further notice. If there are any questions, please contact our billing department at 214-382-9960.

Patient Signature: _____ **Date:** _____
Guarantor/Guardian Signature: _____ **Date:** _____

E AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGMENT — REQUIRED

I have obtained informed consent from the patient to submit this specimen for analysis in accordance with applicable law. I acknowledge and attest that the tests I have requested are medically necessary for the treatment and/or diagnosis of my patient and documentation to support medical necessity is recorded in the patient's medical chart. I understand, if applicable to the test requested, that I can order Molecular Infectious Disease syndromic menus as I deem medically necessary. I have certified medical necessity in Clinical Symptoms/History, and I have provided the appropriate diagnosis codes (ICD-10) for each test that I ordered using the CPT codes located at https://cabotlab.com/ noted in Cabot Lab's Annual Notice to Physicians to confirm and support medical necessity and to enable Cabot Lab or its designee to bill effectively on my patient's behalf. I further understand the Centers for Medicare and Medicaid Services (CMS) and other payers require documentation in the patient's medical chart including date of service, tests ordered and documentation to support medical necessity. Upon request, the ordering facility and providers agree to provide complete supporting documentation of the patient medical records to the requesting party, including Cabot Lab or third-party payers, within 72 hours.

Authorized Healthcare Provider Signature: _____ **Date/Time:** _____