# CABOT LAB INFECTIOUS DISEASE REQUISITION FORM

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| Ordering Providers / NPI# | Provider Address | Affix Accession Label |
|---|---|---|
| ☐ _____ | _____ | |
| ☐ _____ | _____ | |
| ☐ _____ | _____ | |
| ☐ _____ | _____ | |

## A PATIENT INFORMATION - PLEASE PRINT LEGIBLY — ALL FIELDS REQUIRED

First Name: _____ Last Name: _____ Suffix: _____ MI: _____

Address: _____ City: _____

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

Date of Birth: _____ Race: (Select One) Ethnicity: (Select One) Gender: ☐ Male ☐ Female

**Sample Date & Time 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: ☐ Insurance ☐ Patient/Self-pay ☐ Client

**For Insurance Only:**

Insured Name: _____ Relationship to Insured: (Select One) DOB: _____

Primary Insurance: _____ Subscriber ID: _____

Secondary Insurance: _____ Subscriber ID: _____

**ICD-10 Diagnosis Code**

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

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

### ☐ URINARY TRACT INFECTION ☐ Tier I with ABR ☐ Tier II with ABR ☐ Comprehensive (Tier I with ABR and Tier II with ABR)

**SAMPLE TYPE:** ☐ Urine

**Tier I with ABR**

**Bacterial**
Acinetobacter baumannii
Aerococcus urinae
Citrobacter freundii
Enterobacter aerogenes,Enterobacter cloacae
Enterococcus faecalis, Enterococcus faecium
Escherichia coli
Klebsiella oxytoca, Klebsiella pneumoniae
Morganella morganii
Proteus mirabilis, Proteus vulgaris
Providencia stuartii
Pseudomonas aeruginosa
Staphylococcus aureus
Staphylococcus saprophyticus
Streptococcus pneumoniae
Ureaplasma urealyticum, parvum

**Fungal**
Candida group 1 (Candida albicans, C.tropicalis, C. parapsilosis, C. dubliniensis)
Candida group 2 (Candida auris, Candida glabrata)

**Tier II with ABR**

**Bacterial**
Staphylococci Coag-Neg (epidermidis, haemolyticus, lugdunensis)
Streptococcus agalactiae (Group B)
Streptococcus pyogenes (Group A)
Viridans Streptococcus Group

**Fungal**
Candida krusei

**Tier I Antibiotic Resistance Genes (ABR)**
IMP-16, IMP-7, NDM, VIM[1]
TEM, SHV, MIR[2]
PER-1, PER-2, VEB-1[3]
ampC, FOX, ACC, KPC[4]
OXA-48, CTX-M, GES[5]
dfr A1, dfr A5, sul1, sul2[6]
ErmA, ErmB, ErmC[7]
mel (mefA), Cfr[7]
MecA[8]
QnrA, QnrS, QnrB[9]
VanA, VanB, VanC[11]

**Tier II Antibiotic Resistance Genes (ABR)**
ErmA, ErmB, ErmC[7]
mel (mefA), Cfr[7]
MecA[8]
VanA, VanB, VanC[11]

### ☐ SEXUALLY TRANSMITTED INFECTION

**SAMPLE TYPE:** ☐ Urine ☐ Swab **SAMPLE SOURCE:** (Select One)

**Bacterial**
Chlamydia trachomatis
Gardnerella vaginalis
Haemophilus ducreyi
Mycoplasma genitalium, Mycoplasma hominis
Neisseria gonorrhoeae
Treponema pallidum

**Parasite**
Trichomonas vaginalis

**Viral**
HSV1
HSV2
Human papillomavirus type 16
Human papillomavirus type 18,
Human papillomavirus type 45
Human papillomavirus type (HPV 31, 33, 39)
Human papillomavirus type (HPV 52, 59, 68)

**Antibiotic Resistance Genes (ABR)** ErmA, ErmB, ErmC[7] mel (mefA), Cfr[7]

### ☐ BACTERIAL VAGINOSIS / AEROBIC VAGINITIS

**SAMPLE TYPE:** ☐ Urine ☐ Swab **SAMPLE SOURCE:** (Select One)

Atopobium vaginae, BVAB2, Mobiluncus curtsii, Mobiluncus mulieris
Enterococcus faecalis, Enterococcus facecium
Escherichia coli
Gardnerella vaginalis
Megasphera 1, Megasphera 2
Staphylococcus aureus
Streptococcus agalactiae (Group B Strep)

**Antibiotic Resistance Genes (ABR)**
IMP-16, IMP-7, NDM, VIM[1]
TEM, SHV, MIR[2]
PER-1, PER-2, VEB-1[3]
ampC, FOX, ACC, KPC[4]
OXA-48, CTX-M, GES[5]
dfr A1, dfr A5, sul1, sul2[6]
MecA[8]
QnrA, QnrS, QnrB[9]
VanA, VanB, VanC[11]

This assay has been designed by ThermoFisher Scientific and its performance criteria have been validated by Cabot Lab. This test has not been cleared or approved by the Food and Drug Administration (FDA). Such approval is not necessary as Cabot Lab is operating under a high-complexity CLIA approved environment. Limitations: False negative results may occur if a specimen is improperly collected, transported, handled, inhibitors are present in the specimen, spontaneous mutations within target sequence are present, or if sample is below the limit of detection of the test. Clinical correlation, patient history, and other diagnostic information should be used in addition to the RT-PCR results for diagnosis and treatment purposes.

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## ☐ WOMEN'S HEALTH

**SAMPLE TYPE:** ☐ Urine ☐ Swab **SAMPLE SOURCE:** (Select One)

**Bacterial**
Atopobium vaginae, BVAB2, Mobiluncus curtisii, Mobiluncus mulieris
Chlamydia trachomatis
Gardnerella vaginalis
Haemophilus ducreyi
Megasphera 1, Megasphera 2
Mycoplasma genitalium, Mycoplasma hominis
Neisseria gonorrhoeae
Prevotella bivia
Streptococcus agalactiae (Group B)
Treponema pallidum
Ureaplasma urealyticum, parvum
Viridans Streptococcus Group

**Fungal**
Candida krusei
Candida group 1 (Candida albicans, C.tropicalis, C. parapsilosis, C. dubliniensis)
Candida group 2 (Candida auris, Candida glabrata)

**Parasite**
Trichomonas vaginalis

**Viral**
HSV1
HSV2
Human papillomavirus type 16
Human papillomavirus type 18, Human papillomavirus type 45
Human papillomavirus type (HPV 31, 33, 39)
Human papillomavirus type (HPV 52, 59, 68)

**Antibiotic Resistance Genes (ABR)** ErmA, ErmB, ErmC[7] mel (mefA), Cfr[7]

## ☐ WOUND ☐ Tier I with ABR ☐ Tier II with ABR ☐ Comprehensive (Tier I with ABR and Tier II with ABR)

**SAMPLE TYPE:** ☐ Swab **SAMPLE SOURCE:** (Select One)

**Tier I with ABR**
**Bacterial**
Acinetobacter baumannii
Bacteroides fragilis
Bartonella henselae
Clostridium perfringens, Clostridium septicum
Corynebacterium striatum
Escherichia coli
Francisella tularensis
Finegoldia magna
Mycobacterium kansasii, Mycobacterium intracellulare
Nocardia asteroides
Pasteurella multocida
Peptoniphilus harei, Peptoniphilus ivorii
Peptostreptococcus spp
Pseudomonas aeruginosa
Staphylococci Coag-Neg (epidermidis, haemolyticus, lugdunensis)
Staphylococcus aureus
Streptococcus pneumoniae
Streptococcus pyogenes (Group A)

**Fungal**
Candida krusei
Candida group 1 (Candida albicans, C. tropicalis, C. parapsilosis, C. dubliniensis)
Candida group 2 (Candida auris, Candida glabrata)

**Tier II with ABR**
**Bacterial**
Actinomyces israelii
Citrobacter freundii
Enterobacter aerogenes, Enterobacter cloacae
Enterococcus faecalis, Enterococcus faecium
Fusobacterium necrophorum, Fusobacterium nucleatum
Klebsiella oxytoca, Klebsiella pneumoniae
Malassezia furfur
Morganella morganii
Proteus mirabilis, Proteus vulgaris
Providencia stuartii

**Tier I Antibiotic Resistance Genes (ABR)**
IMP-16, IMP-7, NDM, VIM[1]
TEM, SHV, MIR[2]
PER-1, PER-2, VEB-1[3]
ampC, FOX, ACC, KPC[4]
OXA-48, CTX-M, GES[5]
dfr A1, dfr A5, sul1, sul2[6]
ErmA, ErmB, ErmC[7]
mel (mefA), Cfr[7]
MecA[8]
QnrA, QnrS, QnrB[9]
VanA, VanB, VanC[11]

**Tier II Antibiotic Resistance Genes (ABR)**
IMP-16, IMP-7, NDM, VIM[1]
TEM, SHV, MIR[2]
PER-1, PER-2, VEB-1[3]
ampC, FOX, ACC, KPC[4]
OXA-48, CTX-M, GES[5]
QnrA, QnrS, QnrB[9]
VanA, VanB, VanC[11]

## ☐ RESPIRATORY

**SAMPLE TYPE:** ☐ Swab **SAMPLE SOURCE:** (Select One)

**Bacterial**
Streptococcus pyogenes (Group A)
Pseudomonas aeruginosa
Staphylococcus aureus

**Viral**
Coronavirus 229E, Coronavirus HKU1, Coronavirus NL63, Coronavirus OC43 Human Bocavirus (HBoV)
Influenza A
Influenza B
Metapneumovirus
Parainfluenza Virus 1/2/3
Parainflunenza Virus 4
Respiratory Syncytial Virus A
Rhinovirus 1

**Antibiotic Resistance Genes (ABR)**
IMP-16, IMP-7, NDM, VIM[1]
TEM, SHV, MIR[2]
PER-1, PER-2, VEB-1[3]
ampC, FOX, ACC, KPC[4]
OXA-48, CTX-M, GES[5]
dfr A1, dfr A5, sul1, sul2[6]
ErmA, ErmB, ErmC
mel[7] (mefA), Cfr[7]
MecA[8]
QnrA, QnrS, QnrB[9]
VanA, VanB, VanC[11]

**Antibiotic Resistance Genes (ABR)**
1 Carbapenemase and Metallo-beta-lactamase Resistance
2 Class A and C Beta-lactam Resistance
3 Class A and Plasmid ESBL Resistance
4 Class C Beta-lactam Resistance
5 Class D Beta-lactamase Resistance
6 Dihydrofolate and Sulfonamide Resistance
7 Macrolide Resistance
8 Methicillin Resistance
9 Quinolone Resistance
10 Tetracycline Resistance
11 Vancomycin Resistance

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## D PATIENT ACKNOWLEDGMENT — REQUIRED

**Patient Acknowledgment, Consent for Communication, and Irrevocable Assignment of Benefits:** This specimen was provided voluntarily for analysis, and I authorize the CLIA Licensed laboratory service provider and its subsidiaries, affiliates, 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 the label affixed to the specimen are 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. I will irrevocably assign any payment of benefits, claims, rights, and interests related to my healthcare provider's services 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, 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.
I consent to receive healthcare communications/information via text, email, and/or telecommunication from Cabot Lab, LLC and its subsidiaries, affiliates, and designee.
Cabot Lab, LLC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).
**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 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. Should you have 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:** _____