RESPIRATORY & SARS-COV-2 (COVID-19) PCR TEST REQUISITION

CABOT LAB

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FOR CABOT LAB USE ONLY

Ordering Providers	NPI#

■ STAT ■ TRAVEL

■ Employer Based ■ Return to Work/School

PROVIDER INFORMATION

Practice Name:

Provider Name:

Address:

City: | State: | Zip:

Collection Date/Time: | Collector Initials:

Phone: | Fax:

PATIENT INFORMATION

Last Name: | Suffix:

First Name: | MI:

Date of Birth: | Gender ☐Male ☐Female

Address/Apt#:

City: | State: | Zip:

Phone: | County:

Email:

Driver's License / ID: | State Issued:

SSN *(If uninsured)*:

Ethnicity: | Race:

PAYMENT AUTHORIZATION (SELF PAY ONLY)

If you selected Self-Pay, or Uninsured, please fill out the following information

Name on Card:

Billing Address:

City/State/Zip:

Card#: | Expires:

Security Code: *(3 digits on back of card, 4 on front for AmEx)*

Amount to Charge: $

I authorize **Cabot Lab, LLC** to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Signature:

Printed Name: | Date:

BILLING INFORMATION

Primary Insurance:

Member ID: | Group ID:

Insured Name: _____ Relationship to Insured: _____ DOB: _____

Bill to: ☐ Insurance ☐ Patient/Uninsured/Self-Pay ☐ Client Bill
https://cabotlab.com/pay-now/

Please check off inclusion of the following for all orders:

☐ Driver's License

☐ Insurance Card (as applicable)

☐ Demographics Sheet

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

CLINICAL SYMPTOMS/HISTORY

PLEASE CHOOSE ALL THAT APPLY

☐ Fever or chills
☐ Cough
☐ Shortness of breath
☐ Fatigue
☐ Muscle or body aches
☐ Headache
☐ New loss of taste or difficulty breathing
☐ Sore throat
☐ Congestion or runny nose
☐ Nausea or vomiting
☐ Diarrhea
☐ Contact with person that is known to be infected
☐ Recently traveled to an area with widespread ongoing community spread of COVID-19
☐ Other: _____

DIAGNOSIS ICD-10 CODES

☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Covid-19 Clinical History (REQUIRED INFORMATION by HHS and CDC). Please check the appropriate boxes.

Resident in congregate setting?	☐ Yes	☐ No	☐ Unknown	Hospitalized for Covid-19?	☐ Yes	☐ No	☐ Unknown
Employed in Healthcare?	☐ Yes	☐ No	☐ Unknown	ICU for Covid-19?	☐ Yes	☐ No	☐ Unknown
First Test?	☐ Yes	☐ No	☐ Unknown	Pregnant?	☐ Yes	☐ No	☐ Unknown
Symptomatic as defined by CDC?	☐ Yes	☐ No	☐ Unknown				

INFECTIOUS DISEASE TEST ORDERS

When ordering both Respiratory and SARS-CoV-2 (Covid-19), only one sample collection is required.

☐ **RESPIRATORY** (Select the pathogens below) or ☐ **Comprehensive RPP Panel**

SAMPLE TYPE: ☐ Nasopharyngeal Swab ☐ Oropharyngeal Swab ☐ Nasal Swab

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[7]
mel[7] (mefA), Cfr[7]
MecA[8]
QnrA, QnrS, QnrB[9]
VanA, VanB, VanC[11]

☐ **SARS-COV-2 (COVID-19) PCR**

SAMPLE TYPE: ☐ Nasopharyngeal Swab ☐ Oropharyngeal Swab ☐ Nasal Swab

COMPLETE AND SUBMIT ALL PAGES. FAILURE TO DO SO MAY CAUSE DELAYED TESTING AND RESULTS CONTINUE TO PAGE 2

Additional Notes:

PATIENT ACKNOWLEDGMENT & CONSENT

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:** _____

AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGMENT

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.

Provider Signature: _____ **Date:** _____

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
11 Vancomycin Resistance

SARS-CoV-2 (Covid-19) PCR Disclaimer -
This product has not been FDA cleared or approved; but has been authorized under an EUA for use by laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C Section 263a, to perform moderate, high, or waived complexity tests at the Point of Care (POC), i.e., in patient care settings operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation.

For Use Under an Emergency Use Authorization (EUA) Only.

ID Testing Disclaimer -
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.

*Testing was validated and performed at Cabot lab, LLC; 3701 W Plano Pkwy, Suite 128, Plano, TX 75075; CLIA# 37D2057496; Lab Director: Pejman Rahimian, Ph.D., HCLD (ABB), MLS (ASCP).

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