CABOT LAB INFECTIOUS DISEASE REQUISITION FORM

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Laboratory Director: Pejman Rahimian, PhD, HCLD (ABB), MLS (ASCP)

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: _____

Zip: _____ County: _____ Phone: _____ Email: _____

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

Pregnant: ☐ Yes ☐ No

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
https://cabotlab.com/pay-now/

For Insurance Only:

Insured Name: _____ Relationship to Insured: _____ 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 (Select the pathogens below) or ☐ 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

Bacteria
- ☐ 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 (Select the pathogens below) or ☐ Comprehensive STI Panel

SAMPLE TYPE: ☐ Urine ☐ Swab **SAMPLE SOURCE:**

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]

WOMEN'S HEALTH (Select the pathogens below) or ☐ Comprehensive Women's Health Panel

SAMPLE TYPE: ☐ Urine ☐ Swab **SAMPLE SOURCE:**

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]

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.

Revision Date 09.12.2023

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BACTERIAL VAGINOSIS / AEROBIC VAGINITIS (Select the pathogens below) or ☐ Comprehensive BV/AV Panel

SAMPLE TYPE: ☐ Urine ☐ Swab **SAMPLE SOURCE:**

- ☐ 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]

WOUND (Select the pathogens below) or ☐ Tier I with ABR ☐ Tier II with ABR ☐ Comprehensive (Tier I with ABR and Tier II with ABR)

SAMPLE TYPE: ☐ Swab **SAMPLE SOURCE:**

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]

GASTROINTESTINAL (Select the pathogens below) or ☐ Comprehensive GI Panel

SAMPLE TYPE: ☐ Fecal Swab **SAMPLE SOURCE:**

Bacterial

- ☐ Campylobacter jejuni, Campylobacter coli, Campylobacter upsaliensis
- ☐ Clostridioides (Clostridium) difficile, toxin A/B
- ☐ E. coli 0157
- ☐ Plesiomonas shigelloides
- ☐ Salmonella enterica
- ☐ Shiga Toxin-Producing E. coli
- ☐ Shigella sonnei, Enteroinvasive E. coli (EIEC)
- ☐ Vibrio cholerae
- ☐ Vibrio vulnificus, Vibrio parahaemolyticus
- ☐ Yersinia enterocolitica

Parasite

- ☐ Cryptosporidium parvum
- ☐ Cyclospora cayetanensis
- ☐ Cystoisospora belli
- ☐ Entamoeba histolytica
- ☐ Giardia lamblia

Viral

- ☐ Hepatitis A
- ☐ Norovirus GI/GII
- ☐ Rotavirus
- ☐ Sapovirus, Astrovirus

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]
QnrA, QnrS, QnrB[9]
tet B, tet M[10]

NAIL (Select the pathogens below) or ☐ Comprehensive NAIL Panel

SAMPLE TYPE: ☐ Sterile Cup **SAMPLE SOURCE:**

Bacterial

- ☐ Pseudomonas aeruginosa
- ☐ Nocardia asteroides

Fungal

- ☐ Alternaria spp
- ☐ Aspergillus fumigatus, Aspergillus flavus
- ☐ Candida group 1 (Candida albicans, C.tropicalis, C. parapsilosis, C. dubliniensis)
- ☐ Curvularia lunata
- ☐ Epidermophyton floccosum
- ☐ Fusarium keratoplasticum (solani)
- ☐ Geotrichum candidum
- ☐ Malassezia furfur
- ☐ Microsporum ferrugineum, Microsporum audouinii, Microsporum canis
- ☐ Scopulariopsis brevicaulis
- ☐ Scytalidium dimidiatum
- ☐ Trichophyton Group (T. rubrum, T. interdigitale, T. tonsurans)

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]
QnrA, QnrS, QnrB[9]

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 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, 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 Laboratory Test 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 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 that 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's medical records to the requesting party, including Cabot Lab or third-party payers, within 72 hours.

Authorized Healthcare Provider Signature: _____ Date/Time: _____