

**MICROBIOLOGY/MOLECULAR PATHOLOGY
 INFECTIOUS DISEASE REQUISITION**
Toll Free: 866-844-2522
 Local: 319-384-7212
 Fax: 319-384-7213

FOR CLIENT USE ONLY Requisition Date: _____	FOR UIDL USE ONLY UIDL Accn#: _____
Completed By: _____ Phone: _____ Accn# _____	UIDL MRN# _____

PART A – PATIENT INFORMATION - REQUIRED	PART B – PROVIDER INFORMATION - REQUIRED
Patient Name: _____	Referring Facility: _____
Street: _____	Street: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: () _____	Phone: () _____ FAX: () _____
Date of Birth: _____	Referring Physician: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Referring Physician Phone: () _____ FAX: () _____

PART C – SPECIMEN INFORMATION - REQUIRED	
SPECIMEN COLLECTION DATE: _____ SPECIMEN COLLECTION TIME: _____	
REQUIRED ICD-9 codes: 1. _____ 2. _____ 3. _____	
BLOOD:	<input type="checkbox"/> Venipuncture <input type="checkbox"/> Other, specify: _____
BODY FLUID:	<input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Synovial fluid <input type="checkbox"/> CSF, Ventricular <input type="checkbox"/> CSF, Lumbar <input type="checkbox"/> Dialysate
URINE:	<input type="checkbox"/> Mid-stream catch <input type="checkbox"/> Foley catheter <input type="checkbox"/> Straight cath <input type="checkbox"/> Other: _____
STOOL:	<input type="checkbox"/> Feces <input type="checkbox"/> Rectal swab
WOUND/TISSUE:	<input type="checkbox"/> Specify Source: _____
LOWER RESP. TRACT:	<input type="checkbox"/> Expectorated sputum <input type="checkbox"/> Endotracheal aspirate <input type="checkbox"/> Bronchoalveolar lavage <input type="checkbox"/> Bronchial brush biopsy
UPPER RESP. TRACT:	<input type="checkbox"/> Transbronchial brush biopsy <input type="checkbox"/> Bronchial wash
UPPER RESP. TRACT:	<input type="checkbox"/> Throat swab <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Nasal swab <input type="checkbox"/> Nasopharyngeal wash <input type="checkbox"/> Sinus
GENITAL TRACT:	<input type="checkbox"/> Other, specify: _____
GENITAL TRACT:	<input type="checkbox"/> Urethral swab <input type="checkbox"/> Endocervical specimen <input type="checkbox"/> Vaginal specimen
OTHER, specify:	_____

This request to order molecular diagnostic tests from UIDL certifies that the ordering physician obtained informed consent from the patient as required by applicable state or federal laws for each test ordered and has patient authorization permitting UIDL to report results for each test ordered to ordering physician.

Refer to the UIDL TEST DIRECTORY for specimen requirements and CPT Code information at www.healthcare.uiowa.edu/uidl.

INFECTIOUS DISEASE TESTS - REQUIRED	
CULTURES	PCR (cont'd)
<input type="checkbox"/> Aerobic Culture	<input type="checkbox"/> Herpes Simplex Encephalitis by PCR
<input type="checkbox"/> Anaerobic Culture	<input type="checkbox"/> Clostridium difficile Toxin PCR
<input type="checkbox"/> Fungal Culture	<input type="checkbox"/> Chlamydia trachomatis Detection by PCR
<input type="checkbox"/> Gram Stain	<input type="checkbox"/> NGPCR Neisseria gonorrhoeae Detection by PCR
<input type="checkbox"/> Group A Strep Screen (throat)	<input type="checkbox"/> CNPCR Neisseria gonorrhoeae & Chlamydia trachomatis Detection by PCR
<input type="checkbox"/> Group B Strep Screen	<input type="checkbox"/> Cytomegalovirus Quantitation by PCR
<input type="checkbox"/> Stool Culture	<input type="checkbox"/> Enterovirus Qualitative PCR Assay, Spinal Fluid (CSF)
<input type="checkbox"/> Urine Culture	<input type="checkbox"/> HIV Viral Load by PCR
<input type="checkbox"/> OTHER, specify: _____	<input type="checkbox"/> Human Papilloma Virus (HPV) High Risk DNA, Paraffin Block (Include HPV High Risk DNA on blocks)
PCR	<input type="checkbox"/> Human Papilloma Virus (HPV) High Risk DNA, SurePath LBC
<input type="checkbox"/> Hepatitis B Virus DNA, Ultra Sensitive Quantitative PCR	<input type="checkbox"/> Staphylococcus aureus (MRSA/MSSA) by PCR
<input type="checkbox"/> Hepatitis C Genotype	<input type="checkbox"/> Respiratory Virus by PCR (including Influenza A/B)
<input type="checkbox"/> Hepatitis C Virus RNA by PCR, plasma	<input type="checkbox"/> Influenza A/B ONLY
<input type="checkbox"/> Hepatitis E Virus by PCR	<input type="checkbox"/> Van A/Van B Detection by PCR (rule out VRE)

PART D - SEND BILL TO:	<input type="checkbox"/> Referring Institution Name: _____ Phone: _____
- REQUIRED	<input type="checkbox"/> Patient's Insurance (Complete billing information must be provided or referring institution may be billed)
Please note that the correct birth date of all policy holders is required information. Please attach the following to the requisition: (1) a copy of the front/back of patient's insurance card(s). Please designate primary vs. secondary/tertiary coverage, OR (2) a printout with patient demographics and insurance information from your practice management system.	
Medicare will only pay for the services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare standards, Medicare will deny payment for that service or test.	