UIDL
UI Diagnostic Laboratories

UI Diagnostic Laboratories
Department of Pathology
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MICROBIOLOGY LABORATORY REQUISITION

RESET

FOR UIDL USE ONLY: MRN# PATH#
FOR CLIENT USE ONLY: Requisition Date Completed by:

PART A – PATIENT INFORMATION – *Required*			**PART B – PROVIDER INFORMATION – *Required***		
Patient Last Name:			Referring Institution:		
Patient First Name:			Street:		
Street:			City:	St:	Zip:
City:	St:	Zip:	Phone:	Fax:	
Phone:	Fax:		Referring Physician:		
Date of Birth:	Gender: ☐ M ☐ F		Referring Physician Phone:		

PART C - SPECIMEN INFORMATION - ***REQUIRED***

SPECIMEN COLLECTION DATE: _____ SPECIMEN COLLECTION TIME: _____
REQUIRED ICD-10 codes: 1. _____ 2. _____ 3. _____ **NOTE: Use universal transport media (UTM) for viral swabs.**

BLOOD:	☐ Venipuncture	☐ Other, specify: _____				
BODY FLUID:	☐ Peritoneal fluid	☐ Pleural fluid	☐ Synovial fluid	☐ CSF, Ventricular	☐ CSF, Lumbar	☐ Dialysate
URINE:	☐ Mid-stream catch	☐ Foley catheter	☐ Straight cath	☐ Other: _____		
STOOL:	☐ Feces	☐ Rectal swab				
WOUND/TISSUE:	☐ Specify Source: _____	**DERM:**	☐ Derm Swab- lesion	☐ Derm Swab-tissue	☐ Derm Swab- vesicle	
LOWER RESP. TRACT:	☐ Expectorated sputum	☐ Endotracheal aspirate	☐ Bronchoalveolar lavage	☐ Bronchial brush biopsy		
	☐ Transbronchial brush biopsy	☐ Bronchial wash				
UPPER RESP. TRACT:	☐ Throat swab	☐ Nasopharyngeal swab	☐ Nasal swab	☐ Nasopharyngeal wash	☐ Sinus	
	☐ Other, specify: _____					
GENITAL TRACT:	☐ Urethral swab	☐ Endocervical specimen	☐ 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.

TEST(S) REQUESTED: (Please include or attach any additional information such as specimen specifies or pertinent clinical history)

CULTURES	**CULTURES (continued)**
☐ **Aerobic Culture** (respiratory, sterile site, wound, tissue) [LAB4801]	☐ **Quantitative Tissue Culture** [LAB2390]
☐ **Aeronomas Culture** [LAB8526]	☐ **Test of Cure Stool Culture** (Salmonella, Shigella) [LAB8534] If EHEC, call Local Public Health and send specimen to SHL
☐ **AFB Blood Culture** [LAB246]	☐ **Urine Culture** [LAB239]
☐ **Anaerobic Culture** [LAB2210]	☐ **VRE Screen by Culture** [LAB2247]
☐ **Blood Culture** - Adult, Multiple Sets [O120710 and O123906]	
☐ **Blood Culture** – Pediatric [LAB7646]	
☐ **Blood Culture** Panel-Adult Catheter Associated [O116026]	**OTHER**
☐ **Blood Culture** Panel-Peds Catheter Associated [O104801]	☐ **Blood Parasite** Exam (R/O Malaria/Bld Parasites) [LAB2294]
☐ **Fungal Culture** (includes stain) [LAB240] **Suspect Malassezia: ☐ Yes ☐ No**	☐ **Cryptococcus** Antigen [LAB2233]
☐ **Fungal Isolator Blood Culture** [LAB2217]	☐ **Legionella** Antigen Urine [LAB2356]
☐ **Group A Strep** Screen (throat) [O103409]	☐ **Pinworm** Exam (Scotch Tape Preparation) [LAB248]
☐ **Group B Streptococcus** PCR with Reflex Culture for Susceptibility [LAB8018] Penicillin Allergy ☐ Yes ☐ NO	☐ **Pneumocystis** Carinii Pneumonia (PCP) [LAB2384]- ***Note: Sputum specimen is not acceptable for LAB2384***
☐ **KOH Prep** (Fungal Stain, KOH with Calcofluor White) [LAB2354]	☐ **Scabies** Exam [LAB7264]
☐ **Mycobacterial (AFB) Culture** [LAB2208]	☐ **Schistosome** Exam [LAB78625]
☐ **Mycobacterium Tuberculosis** PCR (BAL, sputum, includes culture) [LAB7618]	☐ **Vaginosis/Vaginitis Panel** (Trichomonas, Yeast and Gardnerella) [LAB7263]
☐ **Quantitative Bowel Culture** [LAB2392]	☐

REFER TO UIDL TEST DIRECTORY FOR SPECIMEN REQUIREMENTS AND HANDLING INSTRUCTIONS

PART D – SEND BILL TO: ☐ **Referring Institution** **NOTE: Claims can't be submitted to a Medicaid Program Outside of Iowa**
On date of collection, was patient: **Admission Date:** _____ **Discharge Date:** _____
☐ **Inpatient** ☐ **Outpatient** ☐ **Non-Hospital Patient - Facility name where specimen collected:** _____
(REQUIRED) ☐ **Patient's Insurance** (Complete billing information must be provided or referring institution may be billed)

Primary Insurance Coverage Information			**Secondary Insurance Coverage Information**		
Insured by:			Insured by:		
Claims Address:			Claims Address:		
City:	St:	Zip:	City:	St:	Zip:
Policy/ID #:	Group #:		Policy/ID #:	Group #:	
Name of Subscriber:		DOB:	Name of Subscriber:		DOB:
Relationship to Patient:			Relationship to Patient:		

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.

The purpose of this form is to obtain information necessary for UIDL Pathology Department to perform consultations and/or testing. Failure to properly complete the form may cause delay in the processing of specim

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