UI Diagnostic Laboratories

RESET PRINT

UI Diagnostic Laboratories
Department of Pathology
200 Hawkins Drive, 5231 RCP
Iowa City, Iowa 52242
Toll Free: 866-844-2522
Local: 319-384-7212
Client Services Fax: 319-384-7213
Billing Fax: 319-356-0729

MICROBIOLOGY/MOLECULAR INFECTIOUS DISEASE REQUISITION

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*
Date Collected: _____ **Time**: _____

Specimen Type: ☐ Serum ☐ Plasma ☐ Whole Blood ☐ CSF
☐ Urine (specify): _____
☐ Other (specify): _____

Required ICD-10 codes: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

INFECTIOUS DISEASE TEST MENU

☐ **BK Virus** Quantitative PCR ☐ Blood [LAB2722] ☐ Urine [LAB2721] ☐ **Other Bacterial Cultures:**
☐ **Clostridium difficile** Toxin Screen [LAB8239] **Aerobic Culture, Routine** [LAB 4801]
☐ **Chlamydia trachomatis** Detection by PCR [LAB2223] **Blood Culture** [LAB462]
☐ **Neisseria gonorrhoeae** PCR [LAB2372] **Group A Streptococcus with Reflex Culture** [LAB8017]
☐ **Cytomegalovirus (CMV)** Qualitative by PCR [LAB7480] **Respiratory Culture**[LAB2397]
☐ **Cytomegalovirus (CMV)** Quantitation by PCR Blood (viral load) [LAB2227] **Urine Culture, Routine Aerobic** [LAB239]
☐ **Cytomegalovirus (CMV) Quantitative** PCR [LAB8009]
☐ **Cytomegalovirus (CMV)** Congenital Neonatal Screen [LAB8806] <21 days old ☐ Yes ☐ No Failed 2 hearing tests ☐ Yes ☐ No
☐ **Enteric Panel** Rapid PCR for GI pathogens [LAB8513] NOTE: If Aeromanas testing is required order **Aeromonas Stool Culture (LAB8526)** below.
REQUIRED FOR LAB8513: Has this patient had an Enteric Panel ordered within 3 days of admission or been admitted for >3 days? ☐ YES ☐ NO
If yes, prior approval must be obtained from the UIHC Pathology Resident. Call 319-356-1616 and ask for Pager 4903 (M-F 0800-1700) or 3404 any other time.
☐ **Aeromonas Stool Culture** [LAB8526]
☐ **Enterovirus** Qualitative PCR, Spinal Fluid (CSF) [LAB2240]
☐ **Epstein Barr Virus (EBV) by** Quantitative PCR [LAB7789] Note: This test is for monitoring EBV related disease, not for diagnosis of mononucleosis.
☐ **Hepatitis B** Virus Quantitation PCR (viral load) [LAB3284]
☐ **Hepatitis C** Virus; Quantitative RNA PCR [LAB2465]
☐ **Hepatitis E** Virus PCR [LAB7622]
☐ **HSV [**LAB2467**] /** ☐ **VZV** [LAB7808] by PCR (use of universal transport swab required)
☐ **HIV** Quantitation PCR (viral load) [LAB2468]
☐ **Human Papilloma Virus (HPV) High Risk DNA** [LAB7624]
☐ **Influenza A/B** Panel only by PCR [LAB8654]
☐ **Meningitis/Encephalitis Panel:** viral/bacterial PCR [LAB8514]
☐ **Mycoplasma** PCR (throat) [LAB8573]
☐ **Respiratory Virus** Cascading Panel [LAB8657]
☐ **Respiratory Virus** Panel Cascading Add on [LAB8658]
☐ **RSV Panel** [LAB9070]
☐ **Staphylococcus aureus Screening** PCR (MRSA/MSSA) [LAB5810]
☐ **Trichomonas PCR** [LAB8677]

UIDL TEST DIRECTORY: http://www.healthcare.uiowa.edu/path_handbook/rindex.html

PART D – BILLING – REQUIRED **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:** _____
☐ **Bill Client** **Email Recipient for Invoicing** _____
Name: _____ **Phone:** _____
☐ **Bill Insurance** **PRE-AUTHORIZATION #:** _____ Required for all out of state cases.
See website for a comprehensive guide to UIDL Billing - https://www.healthcare.uiowa.edu/uidl/site/billing_services/index.html

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:

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 specimens. *MSO 10 -2022*