

CT-ST License # CL-0687

Respiratory Viral Requisition Form

1: PATIENT INFORMATION

PATIENT NAME (LAST) (FIRST) (M.I.)				Sex :	BIRTH DATE (MM/DD/YYYY)	Date Collected:	Time Collected:
Social Security #				Electronic Medical Record #		Ordering Physician Name	
						Phone	Fax

PATIENT ADDRESS (STREET)	CITY	STATE	ZIP	PATIENT PHONE #
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MEDICARE PRIMARY

MEDICARE SECONDARY

MEDICAL ASSISTANCE NUMBER	STATE
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POLICY HOLDER Name	POLICY HOLDER DATE OF BIRTH	MEMBER/POLICY #	GROUP #
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RELATIONSHIP OF PATIENT TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	INSURANCE CO. NAME
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PLEASE PROVIDE A COPY OF INSURANCE CARD(S) FOR BILLING PURPOSES

ICD10 DIAGNOSIS CODE(S) FOR TESTS ORDERED (MUST BE PROVIDED)

DX1	DX2	DX3	DX4
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2: Viral Information	3: Test Indications (chosed at least one)	4: Respiratory Viral Panel Includes All of the Following:
Date of Influenza Vaccination (if any): (Month/Day/Year) <hr/> Date of Onset of Symptoms : (Month/Day/Year)	<input type="checkbox"/> Suspected influenza (ICD-10: J11.0) Subcategories include: <input type="checkbox"/> Hospitalized patient <input type="checkbox"/> Person aged >65 years or <2 years <input type="checkbox"/> Pregnant women <input type="checkbox"/> Immuno-compromised or high risk patient <input type="checkbox"/> Person with chronic lung, heart, renal disease <input type="checkbox"/> Close exposure to pigs, poultry or other influenza susceptible animals <input type="checkbox"/> Other:	Viral Targets <ul style="list-style-type: none"> • Influenza A, AH1, AH3, 2009 H1N1 • Influenza B • Respiratory Syncytial Virus A & B • Parainfluenza Virus 1, 2, 3, and 4 • Human Bocavirus • Human Metapneumovirus • Human Rhinovirus/Enterovirus • Adenovirus • Coronavirus HKU1, NL63, OC43, 229E Bacterial Targets <ul style="list-style-type: none"> • Chlamydomphila pneumoniae • Mycoplasma pneumoniae <input type="checkbox"/> Bordetella pertussis (Will only be performed if requested)

5: HEALTHCARE PROVIDER AUTHORIZATION

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law and Genesys's Patient Informed Consent. I agree to provide Genesys, or its designee, any and all additional information reasonably required for this testing to be performed

Signature of Healthcare Provider (Required) _____ Date (Required) _____

6: PATIENT BILLING INFORMATION:

PLEASE INCLUDE A COPY OF THE INSURANCE CARD(S) FOR BILLING PUPPOSES.

<input type="checkbox"/> CLIENT BILL	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> MEDICARE/MEDICAID	<input type="checkbox"/> SELF PAY
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7: PATIENT AUTHORIZATION

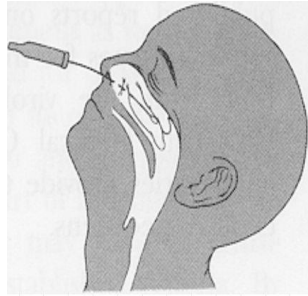
I understand that I am responsible for providing accurate information about my insurance to Genesys Diagnostics Inc. I understand that Genesys Diagnostics Inc. will be providing testing service and billing my insurance. However, I understand that charges that are not covered by my insurance, including any applicable co-payments and deductibles are my responsibility and I agree to pay such charges promptly.

Signature of Patient/Responsible Party (REQUIRED) _____ Date (Required) _____

SPECIMEN COLLECTION INSTRUCTIONS

Nasopharyngeal Swab Method

1. Remove any mucous from the patient's nose, either having the patient blow their nose or using a cotton tipped swab prior to collection.
2. Tilt the patients head back slightly as to straighten the passage from the front of the nose to the nasopharynx
3. Insert swab into one nostril.
4. Rotate swab over surface of posterior nasopharynx
5. Leave swab in place for few seconds in order to absorb cells
6. Withdraw swab from nostril and insert into transport tube containing VTM media as provided, snap the swab at the designated mark, and closing the lid tightly.
7. Label the collection tube with two patient identifiers before shipping.



SPECIMEN SHIPPING INSTRUCTIONS – FEDERAL EXPRESS SHIPPING INSTRUCTIONS

- Use sterile technique for specimen collection and close all containers tightly. **DO NOT FREEZE OR ADD FIXATIVE TO ANY SAMPLE.** Each specimen must be clearly labeled with at least two patient identifiers (patient's name and date of birth), along with the collection date. Secure each specimen container tightly to avoid leakage in transit.
- Complete the test requisition with the patient's demographics and insurance information. There is a secondary pouch in the biohazard bag for the test requisition. The clinical indication is required for appropriate cell culture parameters.
- Place the specimen in the absorbent material inside the enclosed biohazard bag.
- Call GeneSYS Diagnostics Inc. at **(860) 451-8046** to arrange further shipping instructions.
- If instructed that GeneSYS Diagnostics Inc. courier service is picking up the sample, place biohazard bag including corresponding requisition in *large* insulated GeneSYS Diagnostics box.
- Alternatively, if GeneSYS Diagnostics Inc. arranges for a Fedex pick up, place biohazard bag including corresponding requisition in *small* insulated GeneSYS Diagnostics Inc. box and then place box into Fedex Clinical Pak shipping bag. Attach the pre-labeled and prepaid FedEx air bill.
- Contact Laboratory for additional shipping materials, further instructions or any questions: **860-574-9172.**