ADVANTA ANALYTICAL LABORATORIES
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CLIA# 45D2063134 • www.aalabs.com

INFECTIOUS DISEASE REQUISITION

INSTRUCTIONS

1. Please PRINT CLEARLY to ensure proper processing.
2. Provide all primary/secondary insurance information; or attach copies of patient insurance cards (front and back) on a separate sheet appended to this form.
3. Once available, test results can be retrieved through your Advanta Physician Portal. Please email results@aalabs.com for other delivery options.

PATIENT INFORMATION *(required)*

LAST NAME | FIRST NAME | MIDDLE INITIAL | PATIENT ACCOUNT NO.

STREET ADDRESS | CITY | STATE | ZIP CODE

COLLECTION DATE | DATE OF BIRTH | GENDER

RACE/ETHNIC IDENTIFICATION

☐ AFRICAN – AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ JEWISH - ASHKENAZI ☐ JEWISH - SEPHARDIC ☐ NATIVE AMERICAN ☐ OTHER: ________

PATIENT INSURANCE INFORMATION

Please select a billing option & complete the information below. Where applicable, please include a photocopy of insurance card(s) (both sides).
For Self Pay, please include a photocopy of a valid driver's license and phone number.

☐ INFORMATION ATTACHED ☐ INSTITUTION ☐ INSURANCE ☐ MEDICAID ☐ MEDICARE ☐ SELF–PAY

INFECTIOUS DISEASE TESTING PANELS

☐ RESPIRATORY PANEL	☐ GASTROINTESTINAL PANEL	☐ MENINGITIS/ENCEPHALITIS PANEL	☐ BLOOD CULTURE IDENTIFICATION PANEL
The Respiratory Panel (RP) tests for a comprehensive set of 20 upper respiratory viral and bacterial pathogens.	The Gastrointestinal Panel (GI) tests for a comprehensive set of 22 gastrointestinal pathogens. The GI Panel tests stool specimens for common pathogens associated with gastroenteritis.	The Meningitis/Encephalitis (ME) Panel tests for a comprehensive set of 14 of the most common bacteria, viruses, and yeast that cause infections in the central nervous system.	The Blood Culture Identification Panel (BCIP) tests for a comprehensive set of 24 gram positive, gram negative, and yeast pathogens plus 3 antibiotic resistance genes associated with bloodstream infections.
☐ ROUTINE ☐ STAT	☐ ROUTINE ☐ STAT	☐ ROUTINE ☐ STAT	☐ ROUTINE ☐ STAT
ICO–10 CODE(S): *Attach chart notes if available*	**ICO–10 CODE(S):** *Attach chart notes if available*	**ICO–10 CODE(S):** *Attach chart notes if available*	**ICO–10 CODE(S):** *Attach chart notes if available*
________ ________	________ ________	________ ________	________ ________
COLLECTION AND SHIPPING	**COLLECTION AND SHIPPING**	**COLLECTION AND SHIPPING**	**COLLECTION AND SHIPPING**
• Submit Nasopharyngeal Swab in Viral Transport Media from kit provided. • Call for courier immediately or if the sample cannot be received by the lab within 4 hours, please ship refrigerated (2-8°C) overnight for next day delivery.	• Submit stool specimen in the provided Cary-Blair Transport Media vial. • Call for courier immediately or ship at ambient temperature overnight.	• Submit Cerebrospinal Fluid collected via lumbar puncture in sterile tube. • Place sample on cool packs and call for courier immediately or ship overnight on cool packs.	• Submit blood culture bottle identified as positive for organisms as determined by Gram stain by a continuous monitoring blood culture system. • Call for courier immediately. Samples must be received by the laboratory within 8 hours of being flagged positive.

PATIENT CONSENT

REIMBURSEMENT: Advanta Analytical Laboratories (AAL) will make every reasonable effort to obtain reimbursement for the ordered tests above. I hereby authorize AAL to release to Medicare and/or any insurance carrier providing medical benefits to me and any health plan to which I am a member any and all medical or other information necessary for claims processing. I hereby authorize payment of medical insurance benefits to the party who bills for these claims and accepts assignments. I understand that if my insurance company pays me directly for the services provided by AAL that I am responsible for forwarding such payment to AAL. I understand that I am responsible for deductibles/co-payments as required by my plan.

INFORMED CONSENT OF GENETIC INFORMATION: I hereby authorize follow-up of any testing requested to be performed to verify the outcome and/or accuracy of testing. I authorize the specimens taken from me to be retained by Advanta Analytical Laboratories for testing validation and test development and/or quality control/quality assurance purposes. I authorize tissue samples taken from me to be made available to educational institutions, other physicians and/or scientists and companies engaged in research. I understand that samples may be used in or lead to the development of medical products, processes or other items and such products may be used for commercial purposes. I specifically understand and consent to such uses and understand and agree that I will not receive any compensation for such uses nor will I have any financial, property, ownership, licensing or other interest in any products, processes, intellectual property or other outcomes which may result from research utilizing my tissue sample.

PATIENT NAME *(please print)* | PATIENT SIGNATURE | DATE

PHYSICIAN NAME *(please print)* | PHYSICIAN SIGNATURE | DATE

XXXXXX | XXXXXX