



**PATIENT INFORMATION**

LAST NAME  FIRST NAME

DATE OF BIRTH  SEX (M/F)  PHONE

ADDRESS / CITY / STATE / ZIP

**ORDERING PROVIDER**

PROVIDER / CLINIC NAME  NPI #

ACCOUNT #  COLLECTION DATE  COLLECTION TIME

**BILLING / INSURANCE**

Insurance     Client Bill     Patient Self-Pay

INSURANCE CARRIER  MEMBER ID

**PCR PANELS**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Respiratory (20+ targets)    | <input type="checkbox"/> Influenza A/B         | <input type="checkbox"/> RSV                  |
| <input type="checkbox"/> SARS-CoV-2                   | <input type="checkbox"/> Measles               | <input type="checkbox"/> GI Pathogen Panel    |
| <input type="checkbox"/> C. difficile                 | <input type="checkbox"/> Norovirus / Rotavirus | <input type="checkbox"/> H. pylori            |
| <input type="checkbox"/> UTI + Resistance             | <input type="checkbox"/> Wound Pathogen        | <input type="checkbox"/> Nail / Onychomycosis |
| <input type="checkbox"/> Vaginitis (BV/Candida/Trich) | <input type="checkbox"/> STI Panel             | <input type="checkbox"/> HPV Genotyping       |

**DIAGNOSIS CODES (ICD-10)**

ICD-10 CODES

PROVIDER SIGNATURE  DATE