SDI LABS
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CLIA: 05D2103276 LAB ID: CLF00348025

Practice Information

Collector's Initial _____

A PATIENT INFORMATION — REQUIRED

Last Name: _____ First Name: _____ Gender: ☐ M ☐ F

Date of Birth: ____/____/____ ☐ Insurance ☐ Self-Pay ☐ Client Bill

Race (Optional): _____

Ethnicity (Optional): _____

Currently on Antibiotics?

- ☐ No
- ☐ Yes, List antibiotic(s):

_____ _____

ATTACH A COPY OF THE PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

Primary Insurance | Policy # | Group #

Person Insured (Self/Spouse) | DOB of Insured

Secondary Insurance | Policy # | Group #

Person Insured (Self/Spouse) | DOB of Insured

B TEST ORDER — REQUIRED

UTI TEST OPTIONS

☐ MOLECULAR UTI WITH ANTIOBIOTIC RESISTANCE PANEL
☐ URINALYSIS SCREEN, w/ REFLEX TO MOLECULAR UTI WITH ANTIOBIOTIC RESISTANCE PANEL

Date of Collection _____ Time of Collection _____ ☐AM ☐PM

UTI Pathogens Detected: Eschericia coli (E.coli), Staphylococcus aureus (S.aureus), Methicillin-resistance gene (mecA), Staphylococcus saprophyticus (S.saprophyticus) Acinetobacter baumannii (A.baumannii), Pseudomonals aeruginosa (P.aeruginosa), Klebsiella pneumoniae (K.pneumoniae), Citrobacter freundii (C.freundii), Proteus mirabilis (P.mirabilis), Morganella morganii (M.morganii), Enterococcus faecalis (E.faecalis), Streptococcus agalactiae (GBS), Enterobacter cloacae complex (E.cloacae), Candida glabrata (C.glabrata), Candida albicans (C.albicans).

Resistant Markers Screened: Sulfanomide Resistance Gene Sul1 (Sul1), Methicillin-resistance gene (mecA), dfrA1 and dfrA12 (dfrA), dfrA5 and dfrA17 (dfrA_), Klebsiella pneumoniae carbapenemase (KPC), OXA-48-like beta-lactamase (OXA-48 like), Vancomycin resistance gene A (vanA), Vancomycin resistance gene B (vanB), aminoglycoside-6'-acetyltransferase aac6'-Ib (aac6'-Ib), Macrolide resistance gene ErmA (ErmA), Macrolide resistance gene from Tn5398 (ErmB), Macrolide resistance gene ErmC (ErmC), Plasmid AmpC β-lactamase DHA-1 (DHA-1), QnrA and QnrS (QnrA and QnrS), Quinolone and fluroquinolone resistance QnrB (QnrB Clade 1-2),

C COMMONLY USED DIAGNOSIS (ICD-10) CODES — SELECT ONE OR MORE (REQUIRED)

The ICD-10 codes provided are based on AMA guidelines and are for information purposes only. ICD-10 coding is the sole responsibility of the ordering provider.

Urinary

- ☐ B37.49-Other urogenital candidiasis
- ☐ N02-Recurrent and persistent hematuria
- ☐ N30.1-Interstitial cystitis (chronic)
- ☐ N30.11-Interstitial cystitis (chronic) with hematuria
- ☐ N30.2-Other chronic cystitis
- ☐ N30.4 Acute Cystitis
- ☐ N34.1-Nonspecific urethritis
- ☐ N39.0-Urinary tract infection, site not specified
- ☐ N39.4-Other specified urinary incontinence
- ☐ N39.41-Urge incontinence
- ☐ N 41.8 - other inflammatory diseases of the prostate
- ☐ N41.0-Acute prostatitis
- ☐ O23.1-Infections of bladder in pregnancy
- ☐ O23.2-Infections of urethra in pregnancy
- ☐ O23.4-Unspecified infection of urinary tract in pregnancy
- ☐ O23.9 Other and unspecified genitourinary tract infection in pregnancy
- ☐ R10.30-Lower abdominal pain, unspecified
- ☐ R30.0 - Dysuria
- ☐ R30.9- Painful micturition, Unspecified
- ☐ R31.1-Benign essential microscopic hematuria
- ☐ R32-Unspecified urinary incontinence
- ☐ R33-Retention of urine
- ☐ R35.0-Frequency of micturition
- ☐ R39.15 - Urgency of Urination

Antibiotic Resistance

- ☐ Z16.30 Resistance to unspecified antimicrobial drugs
- ☐ Z16.31 Resistance to antiparasitic drug(s)
- ☐ Z16.32 Resistance to antifungal drug(s)
- ☐ Z16.33 Resistance to antiviral drug(s)
- ☐ Z16.35 Resistance to multiple antimicrobial drugs
- ☐ Z16.39 Resistance to other specified antimicrobial drugs
- ☐ Z16.341 Resistance to single antimycobacterial drug
- ☐ Z16.342 Resistance to multiple antimycobacterial drugs

OTHER: _____

D PATIENT ACKNOWLEDGMENT — REQUIRED

I certify that I have voluntarily provided a fresh and unadulterated specimen for analytical testing. The information provided on this form and on the label affixed to the specimen is accurate. I hereby authorize SDI Labs or its assignee to bill any and all insurance/health coverage on my behalf for laboratory services rendered by a performing CLIA Laboratory. I irrevocably assign to and direct that payment be made to SDI LABS . I also authorize SDI Labs to release any information required for billing and reimbursement. I further authorize a performing CLIA Laboratory to release the results of this testing to the treating authorized healthcare provider or facility. I acknowledge that SDI Labs may be out-of-network facility/provider with my insurance provider. I am also aware that in some circumstances my insurance provider may send payment directly to me. I agree to endorse the insurance check and forward it to SDI Labs within 15 days of receipt as payment towards the lab services provided by a performing CLIA Laboratory. I acknowledge that I am responsible for any amounts not covered by my insurer including any deductibles and co-payments/co-insurance. I understand that a performing CLIA Laboratory may use my specimen and any testing performed on that specimen for research and development so long as the information has been de-identified pursuant to law.

Patient Signature: _____ **Date:** _____

E AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGMENT — REQUIRED

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered, and documentation to support medical necessity

Provider Signature: _____ **Date:** _____