PCR PANEL REQUEST FORM

PATIENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS

CITY STATE ZIP CODE

DOB PATIENT TELEPHONE NUMBER

GENDER: FEMALE ☐ MALE ☐

CLIENT

CLINIC NAME

ORDERING PHYSICIAN

PHYSICIAN SIGNATURE

The attending physician authorizes GENEX laboratories to perform the test requested on this form

***Ordering Clinician Acknowledgement**: I acknowledge that the tests ordered are medically necessary, and if ordered for the purpose of screening or the likelihood of payment denial has been explained to the patient, prior to obtaining the laboratory specimen, who has signed the Advanced Beneficiary Notice and agreed to be financially responsible for payment of denied tests.*

PATIENT INSURANCE INFORMATION- *PLEASE ATTACH INSURANCE CARD COPY*

PRIMARY INSURANCE CARRIER PRIMARY INSURANCE POLICY NO. PRIMARY INSURANCE GROUP NO.

TESTS REQUESTED

- ☐ RESPIRATORY PCR PANEL
- ☐ PNEUMONIA PANEL
- ☐ NAIL FUNGUS PCR PANEL
- ☐ UTI
- ☐ GI
- ☐ WOUND PCR PANEL

ICD-10 CODES

☐ **R05.3** Chronic Cough ☐ **R06.02** Wheezing ☐ **J449** COPD ☐ **E11.43** Type 2 Diabetes mellitus with diabetic autonomic (poly) neuropathy
☐ **R50.9** Fever, unspecified ☐ **D70.9** Neutropenia, unspecified
☐ **J12.9** Viral Pneumonia ☐ **J20.9** Acute Bronchitis, unspecified

☐ **B35.1** Onychomycosis due to dermatophyte ☐ **L60.0** Ingrowing nail ☐ **L60.1** Oncholysis ☐ **L60.2** Onychogryphosis ☐ **L60.3** Nail dystrophy ☐ **L60.4** Beau's lines ☐ **L60.5** Yellow Nail syndrome

☐ N390 UTI ☐ R350 Urinary Frequency ☐ R339 Urinary Retention

☐ R1013 Epigastric pain ☐ R509 Fever ☐ R197 Diarrhea

☐ T81.49XA Initial Encounter ☐ T81.49XS Sequela ☐ S81.802D Lower leg, unspecified ☐ T14 UB location ☐ S81.009 a Knee unspecified ☐ L02.0 Cutaneous Abscess ☐ T81.49XD Subsequent Encounter ☐ L08.9 Local skin infection subcutaneous tissue, unspecified ☐ S81.804S Lower Leg Sequela ☐ L08.89 Other specified local skin infection and sub tissue

PATIENT CONSENT

***INFORMED CONSENT OF TEST INFORMATION:** I consent to having the aforementioned analysis performed and the results of the analysis made available to my physician. This signed test request form authorizes DiaMed Laboratory to perform the test and disclose the results to my medical practitioner. No tests other than those requested above will be performed. I authorize DiaMed Laboratory Services to retain this specimen for future testing as requested.*

PATIENT NAME (Please Print) PATIENT SIGNATURE DATE

COLLECTION INFORMATION

DATE COLLECTED TIME COLLECTED (AM/PM) COLLECTED BY (NAME AND SIGNATURE)

DIAMED LABORATORY SERVICES
8162 Van Nuys Blvd,
Panorama City, CA 91402
T (818)510-3734
F (818)510-3747

FOR LAB USE ONLY

SAMPLE TYPE

☐ SWAB ☐ NAIL ☐ SPUTUM

RECIVED IN LAB

DATE	TIME	INITIAL