



PNEUMONIA PANEL REQUEST FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS		
CITY	STATE	ZIP CODE
DATE OF BIRTH	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PREFERRED CONTACT PHONE NUMBER

PATIENT INSURANCE INFORMATION - PLEASE ATTACH INSURANCE CARD COPY

PRIMARY INSURANCE CARRIER	PRIMARY INSURANCE POLICY/ID NO.	PRIMARY INSURANCE GROUP NO.
SECONDARY INSURANCE NAME (if any)	SECONDARY INSURANCE POLICY/ID NO.	SECONDARY INSURANCE GROUP NO.

TEST OPTIONS: ICD-10 CODE(S):

LOWER RESPIRATORY

R05.3 Chronic Cough

J449 COPD

R06.02 Wheezing

E11.43 Type 2 Diabetes mellitus with diabetic autonomic (poly) neuropathy

R50.9 Fever, unspecified

D70.9 Neutropenia, unspecified

J12.9 Viral Pneumonia, unspecified

J20.9 Acute Bronchitis, unspecified

PRACTICE/CLINIC INFORMATION

PRACTICE/CLINIC NAME	PRACTICE/CLINIC PHONE #
PRACTICE/CLINIC ADDRESS	

CLINICIAN SIGNATURE

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 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 Genex Laboratories to perform the test and disclose the results to my medical practitioner. No tests other than those requested above will be performed. I authorize Genex Laboratories 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 & SIGNATURE)**

DIAMED LABORATORY SERVICES

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F (818)510-3747

FOR LAB USE ONLY →

RECEIVED IN LAB		
DATE	TIME	INITIAL