MediPath
PATHOLOGY SERVICES
4665 Ponce De Leon Blvd., Coral Gables, FL 33146
Telephone 786-464-0749 • Fax 786-953-5342

MOLECULAR MICROBIOLOGY REQUISITION

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PATIENT INFORMATION

LAST NAME	FIRST NAME	MI

DATE OF BIRTH	MRN/PT.CHART#	SEX ☐ Male ☐ Female

STREET ADDRESS		

CITY	STATE	ZIP

HOME PHONE #	WORK PHONE #

CLIENT INFORMATION

LLC ACCOUNT #	NAME OF LLC	PHONE # FAX #

ORDERING PHYSICIAN / NPI #	

CLIENT ADDRESS	CITY / STATE / ZIP

DATE COLLECTED	TIME COLLECTED ☐ AM ☐ PM

ICD-10 CODE(S):

INSURANCE INFORMATION

PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
STREET ADDRESS	CITY / STATE / ZIP	STREET ADDRESS	CITY / STATE / ZIP
GROUP NUMBER	POLICY NUMBER	GROUP NUMBER	POLICY NUMBER
NAME OF POLICY HOLDER		NAME OF POLICY HOLDER	

CLINICAL HISTORY / PERTINENT CLINICAL INFORMATION

SAMPLE/SPECIMEN

SOURCE(S):

RESPIRATORY MOLECULAR MICROBIOLOGY TESTS

- ☐ SARS-CoV-2 (COVID), PCR
- ☐ Influenza A/B (FLU), PCR
- ☐ Respiratory Syncytial Virus (RSV), PCR
- ☐ Respiratory Panel (Flu A/B, COVID, RSV), PCR
- ☐ Parainfluenza Virus (Types 1-4), PCR
- ☐ Respiratory Virus Panel (Adenovirus, hMPV, Rhinovirus), PCR
- ☐ Respiratory Pathogen Panel (Flu A/B, COVID, RSV, Paraflu, Adeno, hMPV, Rhino), PCR

MICROBIOLOGY MOLECULAR TESTS

SOURCE:

- ☐ HPV Only (E6/E7 mRNA)
- ☐ HPV Genotype (16/18/45)
- ☐ HPV reflex to Genotype (16/18/45)
- ☐ Chlamydia trachomatis (CT), PCR
- ☐ Neisseria Gonorrhea (NG), PCR
- ☐ Trichomonas (TV), PCR
- ☐ Candida Vaginitis (CV), PCR
  Includes *Candida Spp. and Candida Glabrata*
- ☐ Bacterial Vaginosis (BV), PCR
- ☐ Chlamydia Trachomatis/Neisseria Gonorrhoeae (CT/NG), PCR
- ☐ Vaginitis Panel (BV, CV, TV), PCR
- ☐ Vaginitis+ Panel (BV, CV, TV, CT, NG), PCR
- ☐ Group B Streptococcus (GBS), PCR
- ☐ Herpes Simplex Virus (HSV) 1/2 Panel, PCR
- ☐ Mycoplasma genitalium (M.gen), PCR
- ☐ Mycoplasma genitalium/Ureaplasma, PCR (note: send two swabs)

Note: when ordering tests for which Medicare reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient.

Physician Signature: _____ **Date:** _____

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Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.	Patient Name / D.O.B.

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