GENESYS Diagnostics INC.

Gastrointestinal Panel

Requisition Form

*Information required for testing

Patient Information

LAST NAME* | FIRST NAME* | MI | DOB* (MM/DD/YYYY) | SEX

ADDRESS | CITY | STATE | ZIPCODE | PHONE NUMBER | EMAIL ADDRESS

Billing Information (Please include a copy of insurance card(s) for billing purposes.)

*☐ CLIENT BILL ☐ INSURANCE ☐ SELF PAY ☐ MEDICARE/MEDICAID (☐ PRIMARY ☐ SECONDARY) RELATIONSHIP: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

INSURANCE NAME | MEMBER/POLICY ID | GROUP #

POLICY HOLDER NAME | POLICY HOLDER DOB (MM/DD/YYYY) | TEST INDICATION/ICD-10 CODE(S)*

Account Information

FACILITY/PRACTICE NAME* | PHONE NUMBER | FAX NUMBER | ORDERING PHYSICIAN NAME*

Specimen Information: Stool Specimen

COLLECTION DATE: MM/DD/YYYY COLLECTION TIME: 00:00 AM/PM

Test(s) Requested*

☐ **Gastrointestinal Infectious Extended Panel**

Includes:

Bacterial Targets
- Campylobacter
- Clostridium difficile (toxin A/B)
- E. coli O157
- Enterotoxigenic E. coli (ETEC) *lt/st*
- Enteroaggregative E. coli (EAEC)
- Enteropathogenic E. coli (EPEC)
- Plesiomonas shigelloides
- Salmonella
- Shigella/Enteroinvasive E. coli (EIEC)*
- Shiga-like toxin-producing E. coli (STEC) stx1/stx2
- Shigella
- Vibrio cholerae
- Vibrio (parahaemolyticus, vulnificus)
- Yersinia enterocolitica

Parasitic Targets
- Cryptosporidium
- Cyclospora cayetanensis
- Entamoeba histolytica
- Giardia

Viral Targets
- Adenovirus 40/41
- Astrovirus
- Norovirus GI/GII
- Rotavirus A
- Sapovirus (I, II, IV, and IV)

Add-On Tests *Must check boxes for additional tests to be performed*

☐ Calprotectin
☐ Clostridium difficile EIA
☐ Fecal Fat
☐ Helicobacter pylori Stool Antigen EIA
☐ Occult Blood
☐ Pancreatic Elastase
☐ Zonulin Family Peptide

ICD-10 Code(s)*

☐ A09	Infectious gastroenteritis and colitis, unspecified	☐ R11.0	Nausea
☐ K52.89	Other specified noninfective gastroenteritis and colitis	☐ R11.10	Vomiting
☐ K92.1	Melena. Blood in stool	☐ R19.7	Diarrhea, unspecified
☐ R10.84	Generalized abdominal pain	☐ R50.9	Fever
☐ R10.9	Unspecified abdominal pain	☐ OTHER:	

Patient Authorization and Consent

I understand that I am responsible for providing accurate information about my insurance to Genesys Diagnostics Inc. I understand that Genesys Diagnostics Inc. will be providing testing service and billing my insurance. However, I understand that charges that are not covered by my insurance, including any applicable co- payments and deductibles are my responsibility and I agree to pay such charges promptly.

Patient/Guardian Signature:* Date:*

☐ I do not consent to having my deidentified DNA sample used for internal research purposes.

Healthcare Provider Authorization

I certify that (i) this test is medically necessary, (ii) the patient (or authorized representative on the patient's behalf) has given informed consent (which includes written informed consent or written authorization when required by law) to have this testing performed, and (iii) the informed consent obtained from the patient meets the requirements of applicable law. I agree to provide Genesys, or its designee, any and all additional information reasonably required for this testing to be performed.

Healthcare Provider Signature:* Date:*

Medical Necessity Statement: Tests ordered on Medicare patients must follow CMS rules regarding medical necessity and FDA approval guidelines and must include diagnosis, symptoms and reason for testing as indicated in the medical record. If testing does not come under Medicare guidelines for payment a 'signed' Advanced Beneficiary Notice must be included.

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