ELITE CLINICAL LABORATORY

6776 Southwest Freeway Suite #602
Houston, TX 77074
CLIA – 45D1061571
Lab Director - Albert Chen M.D.

Phone: 281-378-2116
Fax: 281-466-2483

Please attach the following documents with this test order:

- ☐ Medical Necessity
- ☐ SOAP Notes
- ☐ Visit History Notes
- ☐ Patient Care-plan
- ☐ Medication List, if any

URINARY TRACT INFECTION REQUISITION FORM

PATIENT INFORMATION

Patient First Name	Patient Last Name	Biological Sex ☐ F ☐ M

Date of Birth (MM/DD/YYYY)	Phone number	Email address	Social Security Number

Address	City	State	Zip

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Jewish(Ashkenazi) ☐ Portuguese ☐ Other

PATIENT INSURANCE INFORMATION -
Attach patient demographics and copy of insurance card

☐ Insurance ☐ Self-Pay ☐ Client Bill

Name of the insurance	Secondary Insurance, If any
Insurance Policy/ID number	Name of the insured
Insurance Group number	Date of Birth of Insured

SPECIMEN AND PRACTICE INFORMATION

Sample Type ☐ Clean catch urine

Provider Name:.....

Practice/Facility Name: .....

Address:.....

City, State, Zip: .....

Phone:.....Fax:.....

NPI # # (optional):.....

Collection date and time:.....

TEST PANEL

UTI PANEL

Bacteria
Acinetobacter Baumannii
Acinobaculum Schaalii
Aerococcus Urinae
Citrobacter Freundii
Citrobacter Koseri
Corynebacterium Urealyticum
Enterobacter Cloacae Complex
Enterococcus Faecalis
Enterococcus Faecium
Escherichia Coli
Klebsiella (Enterobacter) Aerogenes
Klebsiella Oxytoca
Klebsiella Pneumonia
Morganella Morganii
Pantoea Agglomerans
Proteus Mirabilis
Proteus Vulgaris
Providencia Stuartii
Pseudomonas aeruginosa
Serratia Marcescens
Staphylococcus Aureus
Staphylococcus Epidermidis
Staphylococcus Saprophyticus
Streptococcus Agalactiae
Streptococcus Anginosus

Fungus:
Candida Albicans
Candida Glabrata
Candida Krusei
Candida Parapsilosis
Candida Tropicalis

AR-Marker

KPC	IMP	vanA
VIM	OXA-48	vanB
NDM	CTX-M	SHV

ICD-10 codes

☐ N30.1	Interstitial Cystitis (Chronic)	☐ N45.3	Epididymo-orchitis	☐ R39.16	Straining to void
☐ N30.0	Acute Cystitis	☐ N45.4	Abscess of epididymis or testis	☐ R39.9	Unspecified symptoms signs involving GU
☐ N30.80	Other cystitis withput hematuria	☐ N50.3	Cyst of spididymis	☐ R80.8	Other roteinuria
☐ N30.81	Other cystitis with hematuria	☐ N72	Inflammatory disease of cervix uteri	☐ R80.9	Proteinuria, unspecified
☐ N34.1	Nonspecific urethritis	☐ N73.5	Female pelvic peritonitis, unspecified	☐ R81	Glycosuria
☐ N34.3	Urethral syndrome, unspecified	☐ R30.0	Dysuria	☐ R82.0	Chyluria
☐ N41.0	Acute prostatitis	☐ R30.9	Painful micturition, Unspecified	☐ R82.1	Myoglobinuria
☐ N45.1	Epididymitis	☐ R35.0	Frequency of micturition	☐ R82.3	Hemoglobinuria
☐ N45.2	Orchitis	☐ R39.15	Urgency of urination	☐ R82.4	Acetonuria

WRITE - IN CODES : .....

Patient Signature

I hereby assign all rights and benefits under my health plan and all rights and obligations that I and my dependents have under my health plan to Elite Clinical Laboratory its assigned affiliates and authorized representatives for laboratory services furnished to me by Elite Clinical Laboratory. I irrevocably designate, authorize and appoint Elite Clinical Laboratory or its assigned affiliates and their authorized representatives as my true and lawful attorney-in-fact for the purpose of submitting my claims, obtain a copy of my health plan document, Summary Plan Description, disclosure, appeal, litigation or other remedies in accordance with the benefits and rights under my health plan and in accordance with federal or state laws. If my health plan fails to abide by my authorization and makes payment directly to me, I agree to endorse the insurance check and forward it to Elite Clinical Laboratory immediately upon receipt. I hereby authorize Elite Clinical Laboratory its assigned affiliates and authorized representatives to contact me or my health Plan/administrator for billing or payment purposes by phone, text message, or email with the contact information that I have provided to Elite Clinical Laboratory, in compliance with federal and state laws. Elite Clinical Laboratory, its assigned affiliates and their authorized representatives may release to my health plan administrator, my employer, and my authorized representative my personal health information for the purpose of procuring payment of Elite Clinical Laboratory and for all the laboratory services. I understand the acceptance of insurance does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance.

Signature of Patient or Patient Representative / Relationship to Patient: Date:

ORDERING PHYSICIAN SIGN HERE

Physician must only order tests that are medically necessary for the diagnosis or treatment of a patient

I attest that this test is medically necessary for the diagnosis or detection of a disease or disorder and that the results will be used in medical management and care decisions for the patient. Furthermore, all information on this Requisition Form is true to the best of my knowledge. I agree to provide the Care Plan notes and Letter of Intent for this order if the insurance requests the lab to gather the medical necessity for any reason

Ordering Physician Signature: Date: