ACCOUNT INFORMATION

Client Name/Account Number:

Client Address:

City/State/Zip:

Client Phone: | Client FAX:

2110 Research Row, Suite 221
Dallas, Texas 75235
PHONE: 214-645-7057
Toll Free: 877-887-8136
FAX: 214-645-7035
CLIA #45D-0659587, CAP #2723201

UT SOUTHWESTERN MEDICAL CENTER

VERIPATH LABORATORIES

www.veripathlabs.com

REQUIRED ORDER INFORMATION

BILL TO: ❑ Facility / Client
❑ Patient / 3rd party **– Billing information must be provided**

Patient Name: (Last, First, Middle)

Mother's Name: (if infant)

Date of Birth: | Sex: | Patient ID / MR#:

Hospital Inpatient Y / N | Collection Date: | Collection Time: AM PM

Ordering Physician: | NPI:

Phone: | Pager: | FAX:

Clinical Indication for Tests Ordered:

SPECIMEN INFORMATION

Specimen ID#: _____

Infection or Virus expected: _____

❑ Serum
❑ CSF
❑ Urine
❑ Bronchial washing
❑ Bronchial lavage
❑ Induced sputum
❑ Transtracheal aspirate
❑ Nasopharyngeal swab
❑ Vesicle fluid
❑ Swab from base of ulcer
Source: _____
❑ Blood

Anticoagulant
❑ Heparin ❑ EDTA

PATIENT/3RD PARTY BILLING INFORMATION

ICD-9 Code(s)

Medicare patients with non-covered diagnoses must sign Advanced Beneficiary Notice (ABN) on reverse side. ❑ Signed ABN included

ICD-9 Codes applicable to each and every test requested should come only from the ordering physician, represent the reason for the test order at the time of order, and be supported by the patient's medical record. Physicians should order only tests that are medically necessary for the diagnosis or treatment of the patient. Tests ordered should be single laboratory tests appropriate for the patient's medical condition. Tests for screening purposes may be ordered, but may not be reimbursed.

Insured/Responsible Party Name: (if different from patient-Last, First, Middle) | Date of Birth:

Patient's relationship:
❑ Self
❑ Spouse
❑ Dependent
❑ Other

Responsible Party Address: (street, city, State, zip)

Sex: | Phone:

Employer's Name: | Employer's Phone:

Insurance Co. Name: | Insurance Co. Phone:

Insurance Co. Address:

Policy #: | Group #:

❑ Medicare ❑ HMO ❑ Other
❑ Medicaid ❑ PPO

Member ID#:

Referral Authorization/Precertification #:

Name: | Date/Time:

TESTS REQUESTED

SEROLOGY - Antibody Levels

❑ **Adenovirus Antibody** [V ADENO CF]

❑ **Arbovirus IgG Panel** [V ARBO IGG]
- ❑ Eastern Equine Encephalitis IgG IFA
- ❑ La Crosse Encephalitis IgG IFA
- ❑ St. Louis Encephalitis IgG IFA
- ❑ Western Equine Encephalitis IgG IFA

❑ **Arbovirus IgM Panel** [V ARBO IGM]
- ❑ Eastern Equine Encephalitis IgM IFA
- ❑ La Crosse Encephalitis IgM IFA
- ❑ St. Louis Encephalitis IgM IFA
- ❑ Western Equine Encephalitis IgM IFA

❑ **Cytomegalovirus** [V CMV G&M]
- ❑ IgG IFA [V CMV IGG]
- ❑ IgM IFA [V CMV IGM]

❑ **Epstein-Barr Virus[1] Panel** [V EBV PAN]
- ❑ IgG IFA [V EBV IGG]
- ❑ IgM IFA [V EBV IGM]
- ❑ Early Antigen IFA [V EBV EA]
- ❑ Nuclear Antigen IFA [V EBV EBNA]

Herpes Simplex Virus (HSV)
- ❑ Type Specific HSV 1 & 2 IgG ELISA [V HSV EIA]
- ❑ HSV/1 IgM IFA[2] [V HSV1 IGM]
- ❑ HSV/2 IgM IFA[2] [V HSV2 IGM]

Influenza
- ❑ A CF [V INFLA CF]
- ❑ B CF [V INFLB CF]

Mumps
- ❑ IgG IFA [V MUMP IGG]
- ❑ Immune Status IgG IFA [V MUMP SCR]
- ❑ IgM IFA [V MUMP IGM]

Mycoplasma pneumoniae
- ❑ IgG IFA [V MYCG IFA]
- ❑ IgM IFA [V MYCM IFA]

Parvovirus
- ❑ IgG IFA [V PARV IGG]
- ❑ IgM IFA [V PARV IGM]

Rubella
- ❑ IgG IFA [V RUBL IGG]
- ❑ IgM IFA [V RUBL IGM]

Rubeola
- ❑ IgG IFA [V RUBO IGG]
- ❑ Immune Status IgG IFA [V RUBO SCR]
- ❑ IgM IFA [V RUBO IGM]

Toxoplasmosis gondii
- ❑ IgG IFA [V TOXG IFA]
- ❑ IgM IFA [V TOXM IFA]

Varicella zoster
- ❑ IgG IFA [V ZOS IGG]
- ❑ Immune Status IgG IFA [V ZOS SCR]
- ❑ IgM IFA [V ZOS IGM]

West Nile
- ❑ West Nile IgG IFA [WN IGG]
- ❑ West Nile IgM IFA [WN IGM]

[1]Suggested test to run for EBV if suspecting an: Acute illness - IgG and IgM IFA, Immune status - IgG IFA, All others - IgG, IgM, Early Antigen, and Nuclear Antigen

[2]This test is not type specific

DIRECT ANTIGEN DETECTION

❑ Cytomegalovirus pp65 Antigenimia [V CMV ANT]
❑ Herpes simplex Virus 1 [V HSV1 DFA]
❑ Herpes simplex Virus 2 [V HSV2 DFA]
❑ Varicella zoster
❑ Pneumocystis carinii [V PNEU DFA]
❑ **Respiratory Viruses Panel** [V RESP DIR]
- ❑ Adenovirus [V ADENODFA]
- ❑ Influenza A [V INFA DFA]
- ❑ Influenza B [V INFB DFA]
- ❑ Parainfluenza 1 [V PARA1]
- ❑ Parainfluenza 2 [V PARA2]
- ❑ Parainfluenza 3 [V PARA3]
- ❑ Respiratory Syncytial [V RSV DFA]

❑ **Legionella Urine Antigen** [V LEG UR]

VIRAL CULTURE ISOLATION

Suspected Virus: _____

Source: _____

❑ Cytomegalovirus Culture [V CMV]
❑ Herpes Simplex Virus Culture [V HERP]
❑ Viral Culture [V VIRUS]

(Adenovirus, Cytomegalovirus, Coxackie, Echovirus, Enterovirus, Herpes Simples 1, Herpes Simplex 2, Influenza, Measles, Mumps, Parainfluenza, Polio, Respiratory Syncytial, St. Louis Encephalitis, Varicella-zoster)

VERIPATH USE ONLY

Transport Container: **Total # of specimens:** _____
___Yellow ___Green ___Purple ___Syringe ___Conical ___Red ___Blue ___Cup
___Trans Tube ___Block ___Slides ___Formalin ___Other: _____

Transport Conditions:
❑ Frozen ❑ Slushy
❑ Refrig ❑ Room Temp

Destination: ❑ Other _____
❑ Aston ❑ Coag ❑ Cytogen
❑ Flow ❑ Hist ❑ Mol Dx ❑ OncoDx

Initials: