



Address: 3600 South Gessner Rd, STE 110,
Houston, TX 77063
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 Patient Care-plan
 SOAP Notes Medication List, if any
 Visit History Notes

URINARY TRACT INFECTION REQUISITION FORM

PATIENT INFORMATION

Patient First Name		Patient Last Name		Biological Sex <input type="checkbox"/> F <input type="checkbox"/> M	
Date of Birth (MM/DD/YYYY)	Phone Number	Email	Social Security Number		
Address			City	State	Zip

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

PATIENT INSURANCE INFORMATION

SPECIMEN AND PRACTICE INFORMATION

Insurance Self-Pay Client Bill

Speciment Type: **Urine Sample** Urine clean catch

Collection date and time:.....

PRACTICE INFORMATION

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

Provider Name:.....

Practice/Facility Name:

Address:.....

City, State, Zip:

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

NPI # (optional):.....

TEST PANEL

UTI PANEL

Bacteria

Acinetobacter Baumannii
Acinobaculum Schaali
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 for UTI

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

Additional ICD10 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: