Emeritus
MEDICAL TECHNOLOGY
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800-959-2846 | Fax: 949-418-7287

# GI/COLORECTAL REQUISITION

LAB USE ONLY

## CLIENT INFORMATION *(Please check requesting physician)*

## PATIENT INFORMATION *(Green highlighted sections are required information)*

*Please attach a patient face sheet and front and back of primary and secondary insurance card:*

***PATIENT NAME REQUIRED***

☐ **See Attached**

Name (Last, First):_____
Date of Birth: _____/_____/_____ Sex: M F SS#:_____
Address: _____
City: _____State: _____ Zip: _____
Home Phone #: _____ Work Phone #: _____
Medical Record #: _____

## CLINICAL INFORMATION

**Collection Date:** _____

Clinical History: _____

## BILLING INFORMATION

Primary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client
Insurance: _____ Policy # _____ Group #: _____

Ins. Address: _____ City: _____ State: _____ Zip: _____
Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

*I hereby authorize the release to EmeritusDX/Freedom of any medical and insurance information necessary to process claims for services provided by EmeritusDX/Freedom. I hereby authorize EmeritusDX/Freedom to pursue all necessary appeals of full or partial denials of payment in relation to services provided by EmeritusDX/Freedom.*

**Patient Signature** _____

## ICD-10 CODES *(Please check all that apply.)*

### Primary diagnosis codes:

☐ **R19.7/R50.9** Diarrhea, Unspecified with Fever
☐ **R19.7/K92.1** Diarrhea, Unspecified with Hematochezia
☐ **R19.7/R10.9** Diarrhea, Unspecified with Abdominal pain, Unspecified
☐ **R19.7/E87.8** Diarrhea, Unspecified with electrolyte & fluid balance disorders
☐ **R19.7/R19.5** Diarrhea, Unspecified with other fecal abnormalities
☐ **R19.7/R10.13** Diarrhea, Unspecified with Epigastric pain

### Secondary diagnosis codes:

☐ **K90.3** Pancreatic steatorrhea
☐ **A04.71** Enterocolitis due to C. diff, recurrent
☐ **A04.72** Enterocolitis due to C. diff, Not specified as recurrent

### Immunodeficiency diagnosis codes:

☐ **D84.821** Immunodeficiency due to drugs
☐ **D84.89** Other immunodeficiencies
☐ **D81.9** Other combined immunodeficiencies
☐ **D83.8** Other common variable immunodeficiencies
☐ **D84.81** Immunodeficiency due to conditions classified elsewhere
☐ **D80.6** Antibody deficiency with near normal immunoglobulins or with hyperimmunoglobulinemia
☐ **B20** Human Immunodeficiency Virus (HIV) disease

## GASTROINTESTINAL PATHOGEN PANEL – GI DETECT™

Must check off at least one Immunodeficiency diagnosis code in addition to the ICD-10 Codes:

☐ GI Detect™ Comprehensive (Includes Calprotectin & Pancreatic Elastase) ☐ GI Detect™

## NON-PANEL STOOL TESTING

☐ Calprotectin (EIA) ☐ Pancreatic Elastase (EIA)

*(Samples collected in clean vial or sterile collection cup only.)*

**ICD-10 CODE (REQUIRED):**_____

## ANO-RECTAL CYTOLOGY / MOLECULAR TESTING

☐ HSV 1 & 2 *(Aptima Multi-test swab/UTM)*
**ICD-10 CODE (REQUIRED):**_____ **Source** _____

☐ ThinPrep® PAP test ☐ ThinPrep® PAP test and HPV screen
☐ Cervix/Endocervix ☐ Vaginal ☐ Anorectal ☐ Other:_____

☐ CT/NG *Chlamydia/Gonorrhea (Aptima Multi-test swab/UTM)*
**ICD-10 CODE (REQUIRED):**_____ **Source** _____

☐ ThinPrep® PAP test Reflex to HPV if Abnormal
**ICD-10 CODE (REQUIRED):**_____

## GI DETECT™

| | | | |
|---|---|---|---|
| Adenovirus F40/41 | E. Coli 0157 | Helicobacter Pylori | Rotovirus A |
| Astrovirus | Enteroaggregative E. Coli (EAEC) | Helicobacter Pylori (Virulence Factor babA) | Salmonella |
| Campylobacteria | Enterohemorrhagic E. coli (EHEC) | Helicobacter Pylori (Virulence Factor cagA) | Sapovirus (I, II, IV, V) |
| Clostridium difficile Toxin A/B | Enteropathogenic E. Coli (EPEC) | Helicobacter Pylori (Virulence Factor vacA) | Shiga-like-toxin-producing E. Coli (STEC) Stx1/Stx2 |
| Cryptosporidium | Enterotoxigenic E. Coli (ETEC) | Norovirus GI/GII | Shigella/Enteroinvasive E. Coli (EIEC) |
| Entamoeba Histolytica | Giardia Lamblia | Plesiomonas Shigelloides | Yersinia Enterocolitica |

By submission of this requisition and accompanying sample(s), I authorize and direct you to perform the testing indicated above, (I) certify that the ordered tests are reasonable and medically necessary by the diagnosis or treatment of this patient's condition. (I) certify that, to the extent required by the laws of the state in which I provide healthcare services, I have obtained this patient's informed consent to undergo any testing requested hereby, and to have the results reported to me and (I) agree to provide you a copy of this persons signed and dated consent form per your request.

**Physician/Authorized Signature** _____ **Date** _____/_____/_____

*Signature required on this order or in the patient's medical record*

**Please Discard Extra Labels**

1-Complete all required information on requisition. 2-Use appropriate number of labels provided. 3-Place 1 label on each specimen container (not on lid).

NAME: _____ NAME: _____ NAME: _____ NAME: _____
DOB: _____ DOB: _____ DOB: _____ DOB: _____
DOS: _____ DOS: _____ DOS: _____ DOS: _____