Emeritus MEDICAL TECHNOLOGY

GI/COLORECTAL REQUISITION

Lab Use Only

800-959-2846 | Fax: 949-418-7287

CLIENT INFORMATION *PLEASE CHECK REQUESTING PHYSICIAN*

CHECK ONE: ☐ TC ONLY ☐ GLOBAL ☐ CONSULTATION

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

Please attach patient face sheet and front and back of primary and secondary insurance card: ☐ ***See Attached***

Name (Last, First):_____

Date of Birth: ___/___/___ Sex: M F SS#_____

Address: _____

City: _____ State:____ Zip:_____

Home Phone #: _____ Work Phone #: _____

Medical Record #: _____

BILLING INFORMATION

Primary: ☐ Medicare ☐ Medicaid ☐ Insurance ☐ Patient ☐ Client

Insurance: _____ Policy #:_____ Group #: _____

Ins. Address: _____ City: _____ State: ____ Zip: _____

Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

CLINICAL INFORMATION

COLLECTION DATE: _____/_____/_____

Clinical History: _____

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

Patient Signature: _____

ICD-10 CODES

☐	A04.0	Enteropathogenic E. coli infection (EPEC)	☐	D84.9	Immunodeficiency, Unspecified	☐	R11.0	Nausea
☐	A04.1	Enterotoxigenic E. coli infection (ETIC)	☐	D89.89	Other specified disorders involving the immune mechanism	☐	R11.2	Nausea w/ vomiting
☐	A04.8	Other specified bacterial intestinal infections	☐	K51.9	Ulcerative Colitis	☐	R14.0	Bloating
☐	A04.9	Bacterial intestinal infection, unspecified	☐	K52.9	Gastroenteritis	☐	R14.1	Gas pain
☐	A08.0	Rotaviral enteritis	☐	K86.81	Exocrine pancreatic insufficiency	☐	R14.3	Flatulence
☐	A08.11	Acute gastroenteropathy due to Norwalk agent	☐	K90.0	Intestinal Malabsorption, unspecified	☐	R19.5	Occult blood in stool
☐	A09	Infectious gastroenteritis and colitis, unspecified	☐	K92.1	Bloody/watery stool	☐	R19.7	Diarrhea
☐	D81.89	Other combined immunodeficiencies	☐	R10.10	Upper abdominal pain	☐	Z01.818	Pre Procedure Colonoscopy Screening
☐	D82.8	Immunodeficiency associated with other specified major defects	☐	R10.84	Generalized abdominal pain			

GASTROINTESTINAL PATHOGEN PANEL - GI DETECT™

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

☐ GI Detect™ ☐ GI Detect™ Comprehensive (Calprotectin & Pancreatic Elastate)

ADDITIONAL 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***_____

☐ CT/NG *Chlamydia/Gonorrhea* *(Aptima Multi-test swab/UTM)*

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

☐ ThinPrep PAP test ☐ ThinPrep PAP test and HPV screen[2,3]

☐ Cervix/Endocervix ☐ Vaginal ☐ Anorectal ☐ Other:_____

☐ ThinPrep PAP test Reflex to HPV if Abnormal[2,3]

ICD-10 CODE (REQUIRED):_____

PATHOGENS TESTED

- Adenovirus F40/41
- Astrovirus
- Campylobacteria
- Clostridium Difficile Toxin A/B
- Cryptosporidium
- Cyclospora Cayetanensis
- Entamoeba Histolytica
- E. Coli 0157
- Enteroaggregative E. Coli (EAEC)
- Enteropathogenic E. Coli (EPEC)
- Enterotoxigenic E. Coli (ETEC)
- Giardia Lamblia
- Helicobacter pylori
- Helicobacter pylori (Virulence Factor babA)
- Helicobacter pylori (Virulence Factor cagA)
- Helicobacter pylori (Virulence Factor VacA)
- Norovirus GI/GII
- Plesiomonas Shigelloides
- Rotovirus A
- Salmonella
- Sapovirus (I, II, IV, and V)
- Shiga-like-toxin-producing E. Coli (STEC) SLX1/SLX2
- Shigella/Enteroinvasive E. Coli (EIEC)
- Vibrio
- Vibrio Cholera
- 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:_____