Emeritus MEDICAL TECHNOLOGY
181 Technology Drive, Suite 100, Irvine, CA 92618
800-959-2846 | Fax: 949-418-7287

WOMEN'S HEALTH REQUISITION

LAB USE ONLY

CLIENT INFORMATION *(Please check requesting physician)*

PATIENT INFORMATION *(Pink 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.)*

BLADDER/URINE

☐ **N39.0** Urinary Tract Infection
☐ **R31.0** Gross hematuria
☐ **R31.1** Benign microscopic hematuria
☐ **R31.9** Hematuria, unspecified
☐ **Z11.3** Screen for infections w/ sexual mode of transmission
☐ **Z11.8** Screen for other infections
☐ **Other:** _____

PAP/MOLECULAR

☐ **Z12.4** Screen for malignant neoplasm of cervix
☐ **Z01.419** Gyn exam (general/routine) w/o abnormal findings
☐ **Z01.411** Gyn exam (general/routine) w/ abnormal findings
☐ **N76.0** Acute vaginitis
☐ **N94.6** Dysmenorrhea, unspecified
☐ **N87.9** Dysplasia of cervix uteri, unsp.
☐ **Z77.9** High Risk – Other contact with (suspected) exposures to health
☐ **N92.6** Irregular menstruation, unsp.
☐ **D25.9** Leiomyoma of uterus, unsp.
☐ **B95.1** Positive for Group B Strep
☐ **B37.3** Positive for Vaginal Cadidiasis
☐ **N95.0** Postmenopausal bleeding
☐ **Z39.2** Postpartum follow-up
☐ **Z11.51** Screen for human papillomavirus (HPV)
☐ **Z11.59** Screen for other viral diseases
☐ **Z12.72** Screen for malignant neoplasm of vagina
☐ **Z12.89** Screen for malignant neoplasm of other sites
☐ **Other:** _____

PAP SMEAR – ROUTINE & MEDICARE SCREENING (ThinPrep Collection)

Medicare Screening PAP – Patient signed ABN required
Medicare covers screening Pap tests every 2 years for low-risk patients and annually for high-risk patients.

LMP (Required) _____/_____/_____
COLLECTION DEVICE:
☐ BROOM ☐ BRUSH ☐ SPATULA ☐ Other: _____
SOURCE:
☐ Cervical ☐ Ecto/Endocervical ☐ Vaginal ☐ Other: _____

CLINICAL INFORMATION
☐ Postmenopausal ☐ Hysterectomy ☐ Ablation ☐ Postpartum
☐ Vaginal Discharge ☐ Oral Contraceptives ☐ DUB ☐ IUD
☐ Postmenopausal Bleeding ☐ Pregnant, Duration _____ wks
☐ Other: _____

TEST ORDER
☐ Pap Only
☐ Pap, HPV High Risk*
☐ Pap, Reflex HPV High Risk*
☐ Pap, HPV High Risk* & CT/NG
☐ Pap, Reflex HPV High Risk* & CT/NG
☐ Pap, HPV High Risk*, CT/NG & Trichomonas
☐ Pap, Reflex HPV High Risk*, CT/NG & Trichomonas
**HPV High Risk – Reflex to 16 & 18/45 genotype if positive*

BRUSHING/SWAB

COLLECTION METHOD ☐ **Voided Urine** ☐ **Aptima® Swab**

☐ **Aptima® Multitest**
☐ Bacterial vaginosis
☐ Candida species
☐ Candida glabrata
☐ Trichomonas vaginalis
☐ CT/NG C. trachomatis & N. gonorrhea
☐ Mycoplasma genitalium (M. gen)

URINE/INFECTIOUS DISEASE TESTING

COLLECTION METHOD ☐ **Voided Urine** ☐ **Catheterized** ☐ **Bladder Wash**

☐ UTIDX® (PCR Detection with AST)
☐ UTIDX® and STIDX™
☐ STIDX™ (Additional Specimen Tube Required)

TISSUE SPECIMENS SUBMITTED FOR PATHOLOGY EXAMINATION

Specimen #	Biopsy Site(s)	Comments
A	_____	_____
B	_____	_____
C	_____	_____

ADDITIONAL TESTS/NOTES

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: _____

ORGANISMS DETECTED

UTIDX® ID, ABR, & AST

ACINETOBACTER BAUMANNII
ACTINOBACULUM SCHAALII
AEROCOCCUS URINAE
ALLOSCARDOVIA OMNICOLENS
CANDIDA ALBICANS
CANDIDA AURIS
CANDIDA GLABRATA
CANDIDA PARAPSILOSIS
CITROBACTER FREUNDII
CITROBACTER KOSER
COAGULASE NEGATIVE STAPH
CORYNEBACTERIUM RIEGELII
ENTEROBACTER AEROGENES
ENTEROBACTER CLOACAE
ENTEROCOCCUS FAECALIS
ENTEROCOCCUS FAECIUM
ESCHERICHIA COLI
KLEBISELLA OXYTOCA
KLEBSIELLA PNEUMONIAE
MORGANELLA MORGANII
MYCOPLASMA HOMINIS
PANTOEA AGGLOMERANS
PROTEUS MIRABILIS
PROTEUS VULGARIS
PROVIDENCIA STUARTII
PSEUDOMONAS AURUGINOSA
SERRATIA MARCESCENS
STAPHYLOCOCCUS AUREUS
STEPTOCOCCUS AGALACTIAE
UREAPLASMA UREALYTICUM
VIRIDANS GROUP STREP

STIDX™

TRICHOMONAS VAGINALIS
HUMAN PAPILLOMAVIRUS TYPE 16
TRICHOMONAS VAGINALIS
NEISSERIA GONORRHOEAE
HUMAN PAPILLOMAVIRUS TYPE 18
NEISSERIA GONORRHOEAE
CHLAMYDIA TRACHOMATIS
HUMAN PAPILLOMAVIRUS TYPE 31
CHLAMYDIA TRACHOMATIS
GARDNERELLA VAGINALIS
HUMAN PAPILLOMAVIRUS TYPE 33/52/67
GARDNERELLA VAGINALIS

APTIMA® MULTITEST

BACTERIAL VAGINOSIS
CANDIDA GLABRATA
CHLAMYDIA
MYCOPLASMA GENITALIUM
CANDIDA SPECIES
TRICHOMONAS VAGINALIS
GONORRHEA