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PHS label here

Today's Date: / /

☐ Facility ☐ Office ☐ Private ☐ Other

Name of Location: .....

Ordering Physician or NP: | **NPI #:**

FAX Results to: ( ) - ☐ Portal only

Contact Person:

Contact Person Phone #: ( ) -

Email:

PHS TESTING REQUISITION

PATIENT INFORMATION

Name: LAST | Name: FIRST | MI

Date of Birth: / / | Sex: Male ☐ Female ☐ | Phone Number: ( ) -

Address: | Homebound ☐

City: | State: | Zip Code

Caretaker's Name: ..... *Caretaker's Phone Number:*.....

Facility patient is transferring to: .....

SAMPLE COLLECTION INFORMATION

Collection Date: / / | Collection Time: AM / PM | Self Collection: Yes / No
Witness Name:
If yes, please provide witness name.

Collector Name: | Trip Mileage:

BILLING INFORMATION *(Select billing and/or payment options)*

☐ **INSURANCE**
Carrier .....
ID# .....
Grp# .....
Please provide a copy of insurance card(s)

☐ **SELF PAY** *(Select payment type)*
☐ Cash ☐ Credit Card ☐ Check
Payment is expected at the time of collection.

☐ **CLIENT BILL**
Please bill: Facility / Office / Other

☐ **UNINSURED**
***DL #** ..... ***State** .....
***Social Security #** .....
*I attest that I do not have medical insurance. *Required fields*
☐ *Cares Act* ☐ *Other* .....

COVID TESTING ONLY: (Please answer all)

1) Have you been exposed to someone known to have Covid-19 (Z20.822)? Yes / No / Unknown
2) Have you previously been diagnosed with Covid-19 (Z86.16)? Yes / No / Unknown
3) Are you experiencing any of the following symptoms?

Symptom	ICD10 Code	Yes/No
Loss of smell/taste	R43.9	Yes No
Fever	R50.9	Yes No
Shortness of breath	R06.02	Yes No
Cough	R05	Yes No
Headache	R51	Yes No
Chills without fever	R63.83	Yes No
Congestion	R09.81	Yes No
Fatigue	R53.83	Yes No
Sore throat	R07.0	Yes No
Abdominal pain	R10.9	Yes No

4) Do you require a screening test for work, school, travel or event? Yes / No (Z11.52)
If yes, select one: Work / School / Travel / Event
5) First Test? Yes / No / Unknown
6) Employed in Healthcare? Yes / No / Unknown
7) Hospitalized? Yes / No / Unknown
8) ICU? Yes / No / Unknown
9) Symptomatic as defined by CDC? Yes / No / Unk
10) Pregnant? Yes / No / Unknown
11) Staff or resident in congregate care? Yes / No / Unk
If yes, the date of symptom onset: ____/____/____

ICD-10 DX Codes (Required): *Please select or write in appropriate code(s). ICD-10 coding is the sole responsibility of the ordering provider*

Common Respiratory Codes:
- ☐ **R05.0** Cough
- ☐ **R50.9** Fever, unspecified
- ☐ **R06.02** Shortness of breath
- ☐ **J01.90:** Acute Sinusitis, Unspecified
- ☐ OTHER .....

Common Covid-19 Screening Codes:
- ☐ **Z11.52** Encounter for screening for Covid-19
- ☐ **Z20.822** Contact with and (suspected) exposure to Covid-19
- ☐ OTHER .....

Common Urine Codes:
- ☐ **R30.0:** Dysuria
- ☐ **R82.998:** Abn. Finding on urine
- ☐ **R39.16:** Straining to void
- ☐ **R36.0:** Urethral discharge
- ☐ **N41.0:** Acute Prostatitis
- ☐ OTHER .....

Common GI and Wound Codes:
- ☐ **R19.7** Diarrhea
- ☐ **R10. 84** for Generalized abdominal pain
- ☐ **L02.91** Cutaneous abscess
- ☐ **E11.622:** Type 2 diabetes w/ skin ulcer
- ☐ OTHER .....

Common STD and Joint Codes:
- ☐ **L02.91** Cutaneous abscess
- ☐ **N89.9** Vag. discharge and itch
- ☐ **M01.X0:** Direct infection of unsp. joint
- ☐ **L60.9** Nail disorder, unsp
- ☐ OTHER .....

MOLECULAR TESTING PANELS RT-PCR *(select panel to test - See other side for panel description and collection information)*

RESPIRATORY PANELS:
- ☐ COVID 19 (SARS-CoV2)
- ☐ RESPIRATORY VIRAL PANEL
- ☐ RESPIRATORY BACTERIAL PANEL
- ☐ RESPIRATORY BACTERIAL AND VIRAL PANEL

URINE PANELS:
- ☐ COMPLICATED UTI
- ☐ COMMUNITY ACQUIRED UTI
- ☐ RECURRING ACQUIRED UTI
- ☐ PROSTATITIS

STOOL PANEL:
- ☐ GASTROINTESTINAL PATHOGEN PANEL

WOUND PANEL:
- ☐ WOUND/SKIN/SOFT TISSUE INFECTION

STD PANELS:
- ☐ SEXUALLY TRANSMITTED INFECTIONS
- ☐ CT / NG / TV

BODY FLUID PANEL:
- ☐ SEPTIC ARTHRITIS / JOINT FLUID

NAIL FUNGAL PANEL:
- ☐ NAIL FUNGUS

CLINICAL INFORMATION:

Ordering Physician/NP Signature:

..... *Date* .....

Signature indicates that provider finds it medically necessary to order molecular diagnostic tests that are required to properly treat the patient.

Patient's Signature:

..... *Date* .....

I hereby authorize the release of medical information related to the services described herein and authorize payment directly to Precision Health Solutions. I agree to assume responsibility for payment of charges for laboratory services that are not covered by my health insurance.

Note: when ordering tests for which Medicare or Medicaid reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis or treatment of the patient.