

1 Patient Information

Last Name / First Name /
Address
City / State / Zip / County
Phone
DOB
Insurance
Group #
Male
Female
Race:
Ethnicity:
Bill to:
Facility
Uninsured

2 Provider Information

Client Name / Account
Address / APT#
City / State / Zip
Phone
Fax #
Ordering Provider
Specimen Collected
State Collected
Collection Date
Collection Time

3 Medical Necessity

As part of my antibiotic stewardship policy, I find it medically necessary to rapidly determine and differentiate a viral and/or bacterial infection in order to treat with or without appropriate antibiotics.

Provider Signature
Verbal Order
Standing Order

4 Provider Information

The information I have provided on this form is accurate. I authorize Streamline Scientific to release the results of this test to my treating physician or facility.

Provider Signature
Date

5 Panel List

COVID-19 Only
COVID/Flu/RSV
COVID Respiratory Lite
COVID Respiratory
UTI Plus
COVID Vaccination Status
Specimen Source

UTI w/ ABX Resistance
ABX Resistance Markers
UTI Plus
ICD 10 CODES
Specimen Source

Wound/Derm w/ ABX Resistance
ICD 10 CODES
Specimen Source
Antibiotic Resistance
ICD 10 CODES

Vaginitis
ICD 10 CODES
Specimen Source

STI
ICD 10 CODES
Specimen Source
Gastrointestinal
ICD 10 CODES
Specimen Source

Fungal Infection
ICD 10 CODES
Specimen Source
Bacterial Add On
ICD 10 CODES
Specimen Source
Candida
ICD 10 CODES
Specimen Source

6 Please indicate if your patient has taken antibiotics in the past 72 hours:

Yes No