

1 PATIENT INFORMATION

Last Name / First Name / M.I.
Address / APT#
City / State / Zip / County
Phone #
DOB
Insurance
Group #

Male
Female
Race:
Asian
Black
Caucasian
Hispanic
Native American
Other
N/A
Ethnicity:
Hispanic
Non-Hispanic
N/A

2 PROVIDER INFORMATION

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

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.

4 CONSENT FOR TESTING

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

Provider Signature:
Verbal Order
Standing Order
Patient Signature:
Date:

5 PANEL LIST: Please check appropriate panels that address your patients needs. Tests can be ordered individually.

Grid of test panels including COVID-19, UTI w/ ABX Resistance, Wound/Derm w/ ABX Resistance, Vaginitis, STI, Fungal Infection, ICD 10 CODES, and Antibiotic Resistance.

6 PLEASE INDICATE IF YOUR PATIENT HAS TAKEN ANTIBIOTICS IN THE PAST 72 HOURS: YES NO

ICD 10 CODES
Z22.322 Carrier or suspected carrier of MRSA
Z16.19 Resistance to other specified Beta Lactam antibiotics