Patient Name	Patient Name	Patient Name
DOB	DOB	DOB
502750 UA	502750	502750

502750

8430 Juniper Creek Lane, San Diego, CA 92126
Tel: (858) 217-5918 Fax: (866) 789-9585
Lab Director: Nicholas Bevins, M.D., Ph.D.
CLIA #05D0567262

Birdrock LABORATORIES

Customer Information

MOLECULAR DIAGNOSTICS via PCR

Last Name: _____ DOB: ____/____/____

First Name: _____ Biological Sex: ☐ M ☐ F Ordering Provider: _____

Date Collected: ____/____/____ ☐ Attach patient demographics with insurance card

Time Collected: ____:____ AM / PM ☐ Uninsured Patient

Ethnicity: *(for Covid Testing Only)*

Diagnosis Code(s)* _____ _____ _____

☐ White ☐ Black/African-American ☐ Hispanic/Latino/Spanish Origin ☐ Asian ☐ American Indian/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Refused

* Documentation in the patient's medical record must support the medical necessity for ordering the service(s) per Medicare regulations and applicable Local Coverage Determinations (LCDs)

IF ORDERING MULTIPLE PANELS, EACH PANEL WILL REQUIRE ITS OWN COLLECTION TUBE

URINARY TRACT INFECTION TESTS
BD Vacutainer C&S Tube (gray)

☐ **Urinalysis** *UA Preservative Tube Required*

☐ **Complete UTI Panel with Antibiotic Resistance Menu** ☐ **w/ Sensitivity**

Urinary Tract Infection Menu	Antibiotic Resistance Menu
☐ Acinetobacter baumannii	☐ Sulfonamide resistance sul1
☐ Candida albicans	☐ Trimethoprim resistance dfrA
☐ Citrobacter freundii	☐ Trimethoprim resistance dfrA__
☐ Candida glabrata	☐ Aminoglycoside aac6- 1b/aacA4
☐ Enterobacter cloacae	☐ Extended-spectrum B-lactamase pan-TEM
☐ Enterococcus faecalis	☐ Extended spectrum beta lactase DHA-1
☐ Escherichia coli	☐ Klebsiella pneumoniae carbapenase resistance kpc
☐ Methicillin-resistance Staph aureus MRSA	☐ Carbapenem Resistance blaOXA-48
☐ Klebsiella pneumoniae	☐ Glycopeptide resistance vanA2
☐ Morganella morganii	☐ Glycopeptide resistance vanB
☐ Proteus mirabilis	☐ Macrolide resistance ermA
☐ Pseudomonas aeruginosa	☐ Macrolide resistance ermB
☐ Staphylococcus aureus	☐ Macrolide resistance ermC
☐ Staphylococcus saprophyticus	☐ Quinolone and fluroquinolone resistance QnrA and QnrS
☐ Streptococcus agalactiae	☐ Quinolone and fluroquinolone resistance QnrB Clade 1-2

BACTERIAL VAGINOSIS PANEL
E-Swabs

☐ **Complete Panel**	☐ Lactobacillus gasseri	☐ Candida parapsilosis
	☐ Candida albicans	☐ Gardnerella vaginalis
☐ Lactobacillus iners	☐ Candida tropicalis	☐ Atopobium vaginae
☐ Lactobacillus crispatus	☐ Candida glabrata	☐ Trichomonas vaginalis
☐ Lactobacillus jensenii	☐ Candida krusei	

RESPIRATORY PATHOGEN TESTS
Respiratory and Viral Transport Medium (red top)

☐ **Respiratory Pathogen Menu**

- ☐ Influenza A (incl. H1, H3, H5, and H7)
- ☐ Flu Typing (Influenza A serotypes pdH1N1, H3, and H3N2)
- ☐ Influenza B (Yamagata and Victoria lineages)
- ☐ Respiratory Syncytial Virus (incl. type A and B)
- ☐ SARS-CoV2-2 a (ORF1 gene)
- ☐ SARS-CoV2-2 b (ORF8 gene)

SEXUALLY TRANSMITTED INFECTION TESTS
BD Vacutainer C&S Tube (gray)

☐ **Complete STI Panel with Resistance Markers & Pathogenic Flora**

Major STI	Conditionally Pathogenic Flora
Chlamydia trachomatis	Ureaplasma urealyticum
Chlamydia trachomatis LGV	Ureaplasma parvum
Neisseria gonorrhoeae	Mycoplasma hominis
Trichomonas vaginalis	**Resistance Markers**
Mycoplasma genitalium	M.genitalium macrolide resistance
	M.genitalium fluoroquinolone resistance
	N.gonorrhoeae ceftriaxon resistance

☐ SARS-CoV-2 Respiratory via RT-qPCR
Red or Purple Viral Transport Medium

☐ Group B Streptococcus
Nasopharyngeal Swab

AUTHORIZATION/SIGNATURES

DONOR: I certify that the specimen and information provided is my own and has not been substituted or adulterated. I further grant permission for the testing of my specimen for the presence of drugs and/or alcohol. I authorize Birdrock Laboratories to share the information on this form and my test results with my designated insurance carrier if necessary for reimbursement, to appeal any reimbursement denial, and authorize all reimbursements to be paid directly to the laboratory in consideration of services performed. I acknowledge that Birdrock Laboratories may be outside my network of insurance and I may be responsible for the amount due as determined by said insurance. I authorize Birdrock Laboratories to release the results of this testing to the treating authorized healthcare provider or facility.

ORDERING PROVIDER: Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied. I certify that the above ordered tests are medically necessary for the diagnosis and treatment of this patient. I have documented this test in the patient's chart. I acknowledge that Medicare does not generally cover routine screening tests.

Donor Authorization Signature: Date:	Ordering Health Care Provider Signature *(Required)*: Date *(Required)*: