TOPLAB 67-71 East Willow St Millburn, NJ 07041 Ph: 973-250-9898 Fax: 973-200-8087

Practice Information

Ordering Physcian:_____

X _____

Provider's Signature Date: _____

The ordering physician or his/her authorized representative must sign his/her name and indicate the date the test is ordered. This signature constitutes a certification that, with respect to tests reimbursed with Medicare or other third-party payers, the testing is medically necessary and the results will be used in the management of the patient.

Patient Information

Last Name: _____ First Name: _____ MI: _____

SSN: _____-____-_____ ○ F ○ M DOB: ____/____/_____ Phone: (_____) _____

Address: _____ City: _____ State: _____ ZIP: _____

Billing Information

Diagnosis Code(s) _____, _____, _____, _____, _____,

○ Medicare ○ Medicaid ○ Workers Comp ○ No fault ○ Commerical ○ Self

Date of Injury (Workers Comp/ No Fault) _____/_____/_____ ○ AOB attached (No Fault)

Primary Insurance Carrier: _____

Policy I.D. #: _____ Group: _____

Name of Insurance Holder: _____ Holder DOB: _____

Phone: _____ Insurance Address: _____

Secondary Insurance Carrier: _____

Policy I.D. #: _____ Group: _____

Name of Insurance Holder: _____ Holder DOB: _____

Phone: _____ Insurance Address: _____

Specimen Information

Date Collected: _____ By: ____ Time ___:___ ○AM ○PM

Source

□ Cervical □ Vaginal

□ Endocervical □ Other: _____

History

□ Normal Exam □ Postpartum □ Hormone Therapy

□ ABN GYN Exam □ Hysterectomy □ Other: _____

□ Pregnant □ Postmenopausal

LMP

Month Day Year

PAP/HPV from ThinPrep

□ AccuPAP

□ HPV (High Risk)

□ AccuPAP with HPV (High Risk)

□ AccuPAP with reflex to HPV (High Risk) if ASCUS

□ AccuPAP with reflex to HPV (High Risk) if ASCUS or greater

Biopsies

□ BIP1 Biopsy Source: _____

□ BIP2 Biopsy Source: _____

□ BIP3 Biopsy Source: _____

□ BIP4 Biopsy Source: _____

Panels	Please Select a Source				
5000 □ STI Essential	□ ThinPrep □ Aptima® Vaginal Swab □ Urine in a sterile cup transferred in Aptima® urine tubes	□ Aptima® Anal Swab (CT/GC only) □ Aptima® Throat Swab (CT/GC only) □ Aptima® Vaginal Swab (Patient Collected) (CT/GC only)			5007 □ Chlamydia Trachomatis 5008 □ Neisseria Gonorrhoeae 5009 □ Trichomonas Vaginalis
5001 □ Mycoplasma/ Ureaplasma	□ ThinPrep □ Aptima® Vaginal Swab □ Urine in a Sterile Cup	Mycoplasma Genitalium Mycoplasma Hominis Ureaplasma Urealyticum			
5002 □ Bacterial Vaginosis	□ ThinPrep □ Aptima® Vaginal Swab	5010 □ Megaspaera Type 1 5011 □ Mobiluncus spp	5012 □ Atopobium Vaginae 5013 □ Bacteroides Fragilis	5014 □ BV Associated Bacteria2 5015 □ Gardnerella Vaginalis	5016 □ Lactobacillus spp (lacto)
5003 □ Candidiasis	□ ThinPrep □ Aptima® Vaginal Swab	5017 □ Candida Glabrat 5018 □ Candida Tropicalis	5019 □ Candida Krusei 5020 □ Candida Albicans	5021 □ Candida Parapsilosis 5022 □ Candida Dubliniensis	5023 □ Candida Lusitaniae
5004 □ Aerobic Vaginitis	□ ThinPrep □ Aptima® Vaginal Swab	5024 □ Lactobacillus spp (Lacto) 5025 □ Escherichia Coli	5026 □ Staphylococcus Aureus 5027 □ Enterococcus Faecalis	5028 □ Streptococcus Pyogenes 5029 □ Streptococcus Agalactiae	5030 □ Lactobacillus Rhamnosus
5005 □ Herpes Simplex Virus	□ Anogenital Lesion Swab	5031 □ HSV-1 5032 □ HSV-2			
5006 □ Group B Streptococcus	□ Vaginal/Rectal Swab in Liquid Stuart's/Amies	Streptococcus Agalactiae			

UTI □ UTI Panel, PCR W/Refl to ABR, PC

*Positive specimens will be reflexed to antibotic gene resistence to PCR

□ Source: Mid stream clean catch urine collected in a sterile cup and transferred to a urine C&S tube (Grey Top)

□ ENTE	□ STAP	□ CITR	□ SERR	□ MORG
Enterococcus spp	Staphylococcus spp	Citrobacter spp	Serratia spp	Morganella spp
Enterococcus Faecium	Staphylococcus Aureus	Citrobacter Freundii	Serratia Marcescens	Morganella Morganii
Enterococcus Faecalis	Stahpylococcus Saprophyticus	Citrobacter Koseri	□ CND	□ ACIN
□ KLEB	Staphylococcus Epidermis	□ ESCH	Candida spp	Acinetobacter spp
Klebsiella spp	□ PROE	Escherichia spp	Candida Albicans	Acinetobacter Baumannii
Klebsiella Aerogenes	Proteus spp	Escherichia Coli	Candida Other	□ PROV
Klebsiella Oxytoca	Proteus Vulgaris	□ PSEG	□ STRE	Providencia spp
Klebsiella Pneumoniaw	Proteus Mirabilis	Pseudomonas spp	Streptococcus spp	Providencia Stuartii
	□ ENT	Pseudomonas Aeruginosa	Streptococcus Agalactiae	
	Enterobacter spp	□ AER	□ CORY	
	Enterobacter Cloacae Complex	Aerococcus spp	Corynebacterium spp	
		Aerococcus Urinae	Corynebacterium Urealyticum	

Antibiotic Resistance (ABR), PCR

4000 □ Quinole/Floroquinolone (S83L gyrA, D87N gyrA, D87N, qnrS, qnrA)	4004 □ Beta Lactamase Class C Genes (CMY, DHA or FOX)	4008 □ Tetracycline Group of Antibiotics (tetB or tetM)
4001 □ Sulfonamide Resistence Genes (Sul1 & Sul2)	4005 □ Beta Lactamase Class D Genes (OXA 1 like, OXA-23 like or OXA-48 like	4009 □ Vancomycin Group of Antibiotics (VanA or VanB
4002 □ Beta Lactamase Class A Genes (KPC, SHV or CTX-M)	4006 □ Macrolides Resistance Genes (ERM A, B or C)	4010 □ Aminoglycoside Resistence Gene aac(6')-Ib-cr
4003 □ Beta Lactamase Class B Genes (NDM, VIM or IMP)	4007 □ Methicillin Resistence (Mec A)	

Patient Authorization

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information on this form and on the label affixed to the specimen cup is accurate. I authorize TopLab to release the results of this testing to the treating authorized healthcare provider or facility. I hereby authorize my insurance plan to be billed and benefits to be paid directly to TopLab for services I received. I acknowledge that TopLab may be an out-of-network provider with my insurer. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse insurance check and forward it to TopLab within 30 days of receipt. Failure to do so may result in my account being forwarded to Collections and reported to a Credit Bureau. I understand that TopLab may use my specimen and any testing performed on that specimen for research, development and potential publication purposes, so long as the information has been properly de-identified pursuant to law.

Patient Signature Date

PT Name: _____ Date: ___/___/_____

Donor Initials: _____ DOB: _____/____/_____