



Urinary Requisition

Date Specimen Collected		Time Specimen Collected		STAT <input type="checkbox"/>	
Laboratory Use Only					
Accession Number		Date Received		Time Received	
Group/Practice Name			Practice Contact Information		
Ordering Physicians			Address Line 1		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Address Line 2		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	City, State Zip		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phone	Fax	

Patient and Insurance Information					
Currently Not Accepting Medicaid or Managed Medicaid Plans - Contract Pending					
First Name		Last Name		MI	DOB
Address Line 1		Address Line 2		City	State
Home Phone		Cell Phone		Race*	Ethnicity*
Insured's Name		Relationship to Patient		Social Security #	
Home Phone		Cell Phone		DOB	Gender
Primary Insurance			Secondary Insurance		
Group #	ID#	Group #	ID#		
Address			Address		
City	State	Zip	City	State	Zip

Test Panels

Comprehensive Urinary Tract Infection Panel & Antibiotic Sensitivity

Urinary STI Panel (CT, NG, TV, MG)

Individual Urine Tests

Collection Method: Voided Catheterized Clean Catch Other _____

Urinalysis (If abnormal reflex to UTM Panel/ Sensitivity)

Microalbumin

hCG

ICD-10 Codes

<input type="checkbox"/> N39.0 Urinary Tract Infection	<input type="checkbox"/> Z87.440 Personal History of Urinary tract infections
<input type="checkbox"/> R30.0 Dysuria	<input type="checkbox"/> Other _____
<input type="checkbox"/> R50.9 Fever, Unspecified	<input type="checkbox"/> Other _____
<input type="checkbox"/> N42.9 Disorder of prostate unspecified	<input type="checkbox"/> Other _____

This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the ordering provider is authorized by law to order the test(s) requested herein.

Signature of Physician or Other Authorized NPI Provider (REQUIRED) _____

*Race and Ethnicity are required by certain states and the CDC		Accessioner Initials	Cytotech
1 _____	2 _____	1 _____	

Urinary Tract Microbiota Panel

Gram-negative microbiota

Escherichia coli
Klebsiella pneumoniae
Proteus mirabilis
Pseudomonas aeruginosa
Providencia stuartii
Morganella morganii
Klebsiella oxytoca
Enterobacter cloacae
Citrobacter freundii
Enterobacter aerogenes
Acinetobacter baumannii
Proteus vulgaris

Gram-positive microbiota

Enterococcus faecalis
Enterococcus faecium
Streptococcus agalactiae
Staphylococcus saprophyticus

Fungal microbiota

Candida albicans

Urinary Sexually Transmitted Infections Panel

Chlamydia trachomatis (CT)
Neisseria gonorrhoeae (NG)
Trichomonas vaginalis (TV)
Mycoplasma genitalium (MG)