



TEST REQUEST FORM

For Lab Use Only

Accn#: _____
Mailer: _____
Date and time received: _____
Rec'd Condition _____

If information is incomplete or incorrectly filled out, there may be a delay in processing the specimen.

I. ORDERING PHYSICIAN INFORMATION: ALL INFORMATION REQUIRED

Name _____ NPI# _____
Clinic or Institution Name _____
Address _____ City, State, Zip _____
Phone: _____ Reporting Contact name: _____
Reporting Email: _____ Reporting Fax: _____

STATEMENT OF MEDICAL NECESSITY: This requisition constitutes an order for services. I certify the services are medically indicated and necessary and they will assist me in treating my patients.

Physician Signature: _____

II. PATIENT INFORMATION

Name: (Last, first) _____ Date of Birth ____/____/____ M F
Alternate Patient ID: _____ Diagnosis codes: 1 _____ 2 _____ 3 _____ 4 _____
Address _____ City, State, Zip _____
Email: _____ Phone _____

III. BILLING INFORMATION: Coppe Laboratories is a fee-for-service provider.

Payment for testing is to be provided at the time of sample submission. Laboratories will submit a claim with the designated insurance carrier, health plan, or third party administrator. (Coppe Laboratories is not a Medicare provider and does not bill Medicare.)

- Direct payment: Attach check, money order, or a credit card number (MasterCard, VISA, Discover or American Express.)
- Submitting insurance reimbursement: Attach copy (front and back) of patient's insurance information. (Coppe does not bill Medicare.)

Credit Card Number _____ - _____ - _____ Exp. Date _____ CVS _____

Name on Credit Card (if different than Patient name): _____

FOR INSURANCE AUTHORIZATION: I authorize Coppe Laboratories to submit a claim with my designated insurance carrier, health plan, or third-party administrator. I understand that all insurance payments will be reimbursed to me.

Insured party signature: _____ Date: _____

IV. SPECIMEN INFORMATION Date and time collected: ____/____/____ Time ____ AM/PM

<p>New Test Offering FEB 2017 ALLERGY TESTING</p> <p>Plasma (Coppe will process WB to plasma as needed)</p> <p><input type="checkbox"/> US Inhalation Allergy Panel (6001)</p> <p><input type="checkbox"/> US Food Allergy Panel (6002)</p> <p><input type="checkbox"/> US Inhalation and Food Allergy Panels (6003)</p>	<p>TICK / MOSQUITO-BORNE DISEASE TESTING</p> <p>Whole blood (WB) (Coppe will process to plasma as needed)</p> <p><input type="checkbox"/> Lyme Borrelia IgG/IgM EIA Screen (3001)</p> <p><input type="checkbox"/> Lyme Borrelia IgG/IgM Immunoblot (3002)</p> <p><input type="checkbox"/> Powassan virus (POWV) IgG/IgM EIA (3008) (with reflex to IFA if positive)</p> <p><input type="checkbox"/> West Nile Virus (WNV) IgG/IgM EIA (5000)</p> <p>POWV RT-PCR</p> <p><input type="checkbox"/> WB (3007) <input type="checkbox"/> CSF (3010) <input type="checkbox"/> Plasma (3011)</p>	<p>TICK/MOSQUITO-BORNE DISEASE PANELS</p> <p><input type="checkbox"/> 3003: Comprehensive Lyme Borrelia Panel: IgG/IgM EIA (3001) and IgG/IgM Immunoblot Test (3002)</p> <p><input type="checkbox"/> 3009: Powassan Virus Panel (POWV): qRT-PCR, Whole Blood (3007) and IgG/IgM EIA, reflex to IFA if positive (3008 / 3012)</p> <p><input type="checkbox"/> 4007: Acute Tick/Mosquito-borne Disease Panel: Comprehensive Lyme Borrelia Panel (3003); POWV Panel (3009); WNV IgG/IgM EIA (5000)</p> <p><input type="checkbox"/> 4008: Chronic Tick/Mosquito-borne Disease Panel: Comprehensive Lyme Borrelia Panel (3003); POWV IgG/IgM EIA (3008) (with reflex to IFA if positive); WNV IgG/IgM EIA (5000)</p> <p><input type="checkbox"/> 4009: Chronic Tick/Mosquito-borne Disease with HHV-6: Comprehensive Lyme Borrelia Panel (3003); POWV IgG/IgM EIA (3008) (with reflex to IFA if positive); WNV IgG/IgM EIA (5000); HHV-6 mRNA Panel (1110)</p>
<p>HUMAN HERPESVIRUS-6 A and B (HHV-6A, -6B) MOLECULAR TESTING</p> <p>HHV-6 RT-PCR mRNA Panel (1110)</p> <p><input type="checkbox"/> Whole Blood (WB)</p> <p><input type="checkbox"/> Bone Marrow</p> <p><input type="checkbox"/> Cord Blood</p> <p>HHV-6 PCR DNA</p> <p><input type="checkbox"/> Whole Blood (WB) (1112)</p> <p><input type="checkbox"/> Cerebrospinal Fluid (CSF) (1105)</p> <p><input type="checkbox"/> Plasma (1113)</p> <p>Tissue (Fresh Frozen)</p> <p><input type="checkbox"/> PCR DNA (1114)</p> <p>Tissue type _____</p> <p>Hair Follicle/Nail Clipping</p> <p>PCR DNA (1109)</p> <p>Select one <input type="checkbox"/> Hair Follicle (HF) Preferred <input type="checkbox"/> Nail Clipping (NC)</p>	<p>Chromosomally Integrated HHV-6 (ciHHV-6)</p> <p><input type="checkbox"/> ciHHV-6A, -6B Screening Panel (1013)</p> <p>Includes the following:</p> <ul style="list-style-type: none"> • RT-PCR mRNA Panel on Whole Blood • PCR DNA on Whole Blood • PCR DNA on one of the following: <ul style="list-style-type: none"> <input type="checkbox"/> Hair Follicle (HF) Preferred <input type="checkbox"/> Nail Clipping (NC) 	<p>IMMUNOHISTOCHEMISTRY (IHC)</p> <p><i>Please attach pathology report</i> Formalin-fixed paraffin embedded (FFPE) tissue, 6 unstained slides, 4 microns thick</p> <p><input type="checkbox"/> HHV-6 staining with basic interpretation (2001)</p> <p>Tissue type:</p> <p><input type="checkbox"/> Bone Marrow <input type="checkbox"/> Heart</p> <p><input type="checkbox"/> Liver <input type="checkbox"/> Brain</p> <p><input type="checkbox"/> Lung <input type="checkbox"/> GI</p> <p><input type="checkbox"/> Other _____</p>