Virant Diagnostics, Inc.

11002 Veirs Mill Rd, Suite 404
Wheaton, MD 20902
Phone: (877) 888-2973, Fax: (888) 713-3456
CAP #: 954036801, CLIA #: 21D2184276
www.virantdx.com

Respiratory Tract Infection (RTI) Test Requisition Form

Place Barcode Label Here

Specimen Collection Information
Collection Date: ____ / ____ / ______
Collection Time: ____ : ____ ☐ AM ☐ PM

PATIENT INFORMATION

Last Name:	First Name:		Date of Birth:
Email:	Phone:		Gender: ☐ M ☐ F
Address:	City:	State:	Zip:

DIAGNOSIS CODES

☐ R05: Cough	☐ R06.02: Shortness of breath	☐ R07.1: Chest pain on breathing
☐ R09.3: Abnormal sputum	☐ R34.1: Disturbance in smell	☐ R50.9: Fever, unspecified
☐ J06.9: Acute upper respiratory infection, unspecified	☐ J22: Acute lower respiratory infection, unspecified	☐ J01.90: Acute sinusitis, unspecified
☐ J02.9: Acute pharyngitis unspecified	☐ J32.9: Chronic sinusitis, unspecified	☐ J40: Bronchitis, unspecified
☐ J18.9: Pneumonia, unspecified organism	☐ Other:	☐ Other:

PATIENT CONSENT/AUTHORIZATION

I authorize Virant Diagnostics to analyze my/my child's swab samples for the tests requested by my healthcare provider. The tests and their limitations have been explained to me. Test results will only be released to the healthcare providers as specified on the test requisition form.

I authorize Virant Diagnostics to submit claims to my healthcare insurers for the lab services provided. I also authorize Virant Diagnostics and my healthcare provider to release any medical information necessary to the insurers to process this claim. Payment will be made directly to Virant Diagnostics from my insurers. If my insurers pay me directly, I agree to forward the payment to Virant Diagnostics. I understand that I am responsible for any amounts not covered or paid by my insurers. Should there be no insurance coverage, Virant Diagnostics reserves the right to bill me directly.

Patient Signature: ____ **Date:** ____ / ____ / ______

Printed Name: ______________________________ **Relationship:** ☐ Self ☐ Parent ☐ Legal Guardian ☐ Durable Power of Attorney for Health Care

INSURANCE AND PAYMENT INFORMATION

☐ Bill Insurance (Attach copy of insurance card, front and back) ☐ Bill Client ☐ Bill Patient (Cash/Check/Credit Card) ☐ Other:

Primary Plan Name:	Policy Holder Name:
Policy #:	Group #:
Secondary Plan Name:	Policy Holder Name:
Policy #:	Group #:

HEALTHCARE PROVIDER INFORMATION

Provider Name:	NPI:		
Organization:	Phone:		
Address:	City:	State:	Zip:

Provider Authorization Signature: ______________________________________ **Date:** ____ / ____ / ______

TEST MENU

Specimen Type and Requirements: ☐ Anterior nasal swab ☐ Nasopharyngeal swab ☐ Oropharyngeal (throat) swab

The specimen must be collected using the provided universal transport medium (UTM) and refrigerated until shipment. It can be shipped at room temperature.

☐ **Cepheid Group A *Streptococcus* Test** *(Oropharyngeal swab ONLY.)*

☐ **Cepheid Viral Combo Test** (*Anterior nasal swab or nasopharygeal swab ONLY.)*
4 viruses: Influenza A, Influenza B, Respiratory Syncytial Virus (RSV), SARS-CoV-2

☐ **Respiratory I Plus Viral Panel** *(Anterior nasal swab or nasopharygeal swab ONLY. Nasopharyngeal swab is preferred.)*
8 viruses: Adenovirus, Enterovirus, Influenza A (Pan), Influenza B, RSV A/B, Rhinovirus, Human metapneumovirus, SARS-CoV-2

☐ **Respiratory III Plus Bacterial Panel** *(Anterior nasal swab or nasopharygeal swab ONLY. Nasopharyngeal swab is preferred.)*
8 bacteria: *Chlamydia pneumoniae, Moraxella catarrhalis, Klebsiella pneumonia, Staphylococcus aureus, Haemophilus influenzae, Legionella pneumophila, Mycoplasma pneumoniae, Streptococcus pneumoniae*

FOR LABORATORY USE ONLY

Accession #:	Patient ID:	
Client/Physician ID:	Date Received: ____ / ____ / ______	Time Received: ____ : ____ ☐ AM ☐ PM

Please visit webpage at www.virantdx.com/testing-solutions/molecular-microbiology/rti-panel-testing/
and contact us at microbiologylab@virantdx.com or (877) 888-2973 for any inquiries.

Document ID: MIC-TRF-0002-4.0
Last modified on 5/23/2023