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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

☐ R05.9: Cough, unspecified	☐ R50.9: Fever, unspecified	☐ J01.90: Acute sinusitis, unspecified
☐ J02.9: Acute pharyngitis, unspecified	☐ J06.9: Acute upper respiratory infection, unspecified	☐ J18.9: Pneumonia, unspecified
☐ J22: Acute lower respiratory infection, unspecified	☐ J32.9: Chronic sinusitis, unspecified	☐ J40: Bronchitis, unspecified

Additional Codes:

PATIENT CONSENT/AUTHORIZATION

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

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)

Primary Plan Name:	Policy Holder Name:
Policy #:	Group #:
Secondary Plan Name:	Policy Holder Name:
Policy #:	Group #:
☐ **Bill Client** (Based on prior agreement)	☐ **Bill Patient** (Based on prior agreement)

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 swab and universal transport medium (UTM) and refrigerated until shipment.

☐ **COVID-19 PCR Test** for SARS-CoV-2

☐ **Cepheid Group A Strep Test** for *Streptococcus pyogenes (See separate eSwab kit; Oropharyngeal swab and lavender top UTM 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*

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.

FOR LABORATORY USE ONLY

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

Document ID: MIC-TRF-0002-4.2
Last modified on 6/22/2023