



# INFECTIOUS DISEASES REQUISITION

29580 Northwestern Hwy Suite 120, Southfield, MI 48034

(248) 301-6917

www.nwlab.com

## PATIENT INFORMATION

Patient Demo Attached ☐

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Middle Name: \_\_\_\_\_ Sex: ☐ Male ☐ Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
DOB: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Email: \_\_\_\_\_

## Provider Information:

## PRIMARY INSURANCE

☐ Medicare ☐ Medicaid ☐ Commercial ☐ Auto ☐ Workers Comp ☐ Client ☐ Other Insurance

Insurance Name: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Relation to Patient: ☐ Self ☐ Spouse ☐ Guardian

## SPECIMEN INFORMATION

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE COLLECTED INITIAL TIME COLLECTED

## ICD 10 CODES: (ENTER ALL THAT APPLY)

## TESTING ORDERS: PAP SMEAR (CERVICAL CYTOLOGY)

Collection Type: Clinician-collected cervical sample

Select Collection Device: ☐ Hologic ThinPrep

Screening Purpose: ☐ Routine screening ☐ Follow-up to abnormal results ☐ High-risk surveillance

## HPV - BD ONCLARITY (EXTENDED GENOTYPING)

Collection Type (must select one): ☐ ThinPrep ☐ Clinician/Patient collected vaginal swab (FLOQSwab)

Ordering Type (select one): ☐ Primary HPV screening (age >25) ☐ PAP W/ Reflex to HPV (ASCUS only)  
☐ PAP + HPV  
☐ PAP W/ reflex to HPV

Genotype Reporting: Individually Reported: HPV 16, 18, 31, 45, 51, 52 Grouped Genotypes: HPV 33/58, HPV 56/59/66, HPV 35/39/68

## BD MAX VAGINAL PANEL / STI Panel

Collection Type: ☐ Clinician/Patient collected vaginal swab (BD Molecular Swab)  
☐ Urine

Ordering Options (select one or more): ☐ Comprehensive Vaginal Panel ☐ STI Panel (Urine)  
☐ Vaginal Panel ☐ Group B Strep  
☐ STI Panel (BD Molecular Swab)

## MYCOPLASMA / UREAPLASMA / UTI / URINE CULTURE

Collection Type: Patient-collected first-catch urine sample

Ordering Options (select one or more): ☐ Mycoplasma ☐ Ureaplasma ☐ UTI W/ ABR Panel ☐ Urine Culture

Purpose: ☐ Urogenital pathogen evaluation

## PATHOLOGY - BIOPSY

## BLOOD

Type of Procedure	Site of Specimen	Time of Collection		
1			<input type="checkbox"/> BLD-aHAVM = Hepatitis A IgM	<input type="checkbox"/> BLD-HSV1 = Herpes - 1 IgG
2			<input type="checkbox"/> BLD-HAVT = Hepatitis A Total	<input type="checkbox"/> BLD-HSV2 = Herpes - 2 IgG
3			<input type="checkbox"/> BLD-aHBcM = Hepatitis B core Antigen	<input type="checkbox"/> BLD-Rub G = Rubella IgG
4			<input type="checkbox"/> BLD-HBcT2 = HBc Total 2	<input type="checkbox"/> BLD-Syph = Syphilis
			<input type="checkbox"/> BLD-HBsII = Hepatitis B surface Antigen II	<input type="checkbox"/> BLD-Toxo G = Toxoplasma IgG
			<input type="checkbox"/> BLD-aHBs2 = Anti-Hepatitis B surface Antigen 2	<input type="checkbox"/> BLD-Toxo M = Toxoplasma IgM
			<input type="checkbox"/> BLD-aHCV = Hepatitis C	<input type="checkbox"/> BLD-CHIV = HIV Ag/Ab Combo (US)

## PATIENT HISTORY

Last Pap Date:	Last HPV Test Date:	Prior abnormal Pap or HPV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
History of CIN2+ or HSIL? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hysterectomy: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Total <input type="checkbox"/> Cervix Removed	
Currently Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunocompromised (e.g., HIV): <input type="checkbox"/> Yes <input type="checkbox"/> No	DES Exposure in Utero: <input type="checkbox"/> Yes <input type="checkbox"/> No

## TEST REFERENCE GUIDE

Test	Sample Source	Collection Method	Approved Collection Device	Notes
Pap Smear (Cytology)	Cervical, Endocervical, Vaginal	Clinician collected	Hologic ThinPrep	Image Guided
BD Onclarity HPV – Clinician	Cervical, Endocervical, Vaginal	Clinician collected	Hologic ThinPrep	HPV Screen / PAP + HPV PAP w/ reflex to HPV or ASCUS
BD Onclarity HPV – Self	Vaginal	Patient self-collected	FLOQ Swab in transport tube	FDA-cleared for self-collection
BD MAX Vaginal Panel BD MAX STI Panel	Vaginal Urine	Clinician- or self-collected	BD Molecular Swab Sterile urine cup	BV, yeast, trichomonas, CT/GC/TV
Mycoplasma / Ureaplasma	Urine (first-catch)	Patient-collected	Sterile urine cup	Urogenital pathogen detection
UTI PCR & Culture	Urine (first-catch)	Patient-collected	Urine C&S tube	Transfer from Cup to Tube within 20 minutes

## SCREENING GUIDELINES SUMMARY: CERVICAL CANCER SCREENING (ACOG, USPSTF, ASCCP)

- Age <21: No screening
- Age 21–29: Cytology every 3 years
- Age 30–65: HPV primary q5 yrs, Co-testing q5 yrs, or Cytology q3 yrs
- Age >65: Stop if adequate negative history and no high-risk history
- Post-Hysterectomy (cervix removed): Stop unless history of CIN2+ or cancer

## RISK-BASED EXCEPTIONS

### Continue or intensify screening if:

- Immunocompromised (e.g., HIV)
- History of CIN2+ or cervical cancer
- In utero DES exposure
- Inadequate prior screening

## STI & VAGINAL INFECTION SCREENING

Group	Recommendation	Suggested Test
Women <25, sexually active	Annual screening	BD MAX Vaginal Panel (STI)
Women ~25, at risk	Same as above	BD MAX Vaginal Panel
Vaginal complaints	Discharge, odor, irritation	BD MAX BV and/or STI Panel
Suspected recurrent BV	Confirm with molecular testing	BD MAX Vaginal Panel
Non-vaginal urogenital symptoms	Consider urine-based testing	Mycoplasma / Ureaplasma

### Physician Authorization:

- Any pathology, cytology, and thin prep specimens will be forwarded to KC Pathology Laboratory (44400 Van Dyke Ave, Ste 102, Sterling Heights, MI 48314; Phone: (586) 262-4243.
- I understand that while the initial order is placed with North West Labs, the actual testing may be performed by their partner laboratories as specified above.
- I acknowledge that this referral process may affect billing procedures and timeline for results, and I accept this as part of the standard operating procedure for these specific test types.
- I confirm that I have informed my patients about this testing arrangement as appropriate and in accordance with applicable regulations.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Consent and Authorization:

I authorize North West Labs and KC Pathology Laboratory to perform the tests ordered and release results to my provider. I understand my sample will be tested only as authorized and I may withdraw consent prior to processing. I authorize the release of my medical information including test results for submission of personalized reports to my healthcare providers and insurance carrier(s). I request that payment of benefits be made to North West Labs, Inc. on my behalf. If my policy does not allow for direct payment, I agree to relinquish allocated funds to North West Labs, Inc as compensation for services rendered. I also acknowledge that I will be liable for payments of deductibles, co payments and/or co insurance as detailed by my healthcare insurer. I understand that I am liable for charges not covered by my healthcare insurer. I also authorize North West Labs, Inc to appeal insurance claims on my behalf. I acknowledge the benefits, risk and limitations of this testing as described to me by a qualified healthcare provider. My insurance may not cover or pay full amount for testing; I may be responsible for full or part of amount charged due to out of network benefits, deductible and co pays. North West Labs, Inc has my permission to bill my insurance carrier(s), this notice gives me the option to proceed with the procedure or decline. By signing this I have read all of the above and understand it. Medicare Advance Beneficiary Notice: Medicare will only pay for services that it determines to be reasonable and necessary under section 1882 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under the Medicare Program standards, Medicare will deny payment for that service. Medicare usually does not pay for these tests for the reported diagnosis. By signing the Patient/Responsible Party Signature on this requisition, you are confirming your agreement to assume financial responsibility for the payment of these tests.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_