



GASTROINTESTINAL PATHOGEN PANEL REQUISITION FORM

PROVIDER INFORMATION

PATIENT INFORMATION

Last Name _____ First Name _____
Middle Name _____ F M DOB ____/____/____ Phone (____) _____
Address _____ SSN _____-____-_____
City _____ State _____ Zip _____ Pt. ID _____

SPECIMEN COLLECTION

Date ____/____/____
Time ____:____ am pm
Specimen Consistency
Soft
Loose
Watery

BILLING INFORMATION

Bill: Patient Medicare Medicaid Insurance
Insurance Company _____
Member # _____
Group # _____
Address _____
City _____ State _____ Zip _____
Primary Insured's Name _____
Relationship
 Self Spouse
 Child Other

TESTS

ORDERING CODES	BACTERIA & BACTERIAL TOXINS	VIRUSES	PARASITES
<input type="checkbox"/> GPP GASTROINTESTINAL PATHOGEN PANEL (All states except New York)	Salmonella, Shigella, Campylobacter, E.Coli O157, Shiga Toxin 1, Shiga Toxin 2, E.coli ST, E.coli LT, C.difficile Toxin A, C.difficile Toxin B.	Vibrio cholera, Norovirus GI, Novovirus GII, Rotavirus A, Adenovirus 40/41	Giardia lamblia, Entamoeba histolytica, Cryptosporidium
<input type="checkbox"/> V600 GASTROINTESTINAL PATHOGEN PANEL (Only for New York state)	Campylobacter, Clostridium difficile, Toxin A/B, E.Coli O157, Enterotoxigenic E.coli (ETEC), Salmonella, Shigella.	Norovirus GI/GII, Rotavirus A, Adenovirus 40/41, Vibrio cholera	Giardia lamblia, Entamoeba histolytica, Cryptosporidium

DIAGNOSES (ICD-10 CODES)

Physician Signature _____

Date _____