UFHealth
PATHOLOGY LABORATORIES

Practice name _____
Address _____
Email _____
Phone _____ Fax _____

MICROBIOLOGY REQUISITION (NTM)

PATIENT INFORMATION

Full Name (last, first, MI) _____

Sex: ☐ Male ☐ Female **Date of birth** (MM/DD/YYYY) _____

MRN# / Patient ID# _____

Place of service:
☐ Hospital inpatient ☐ Ambulatory surgical center
☐ Hospital outpatient ☐ Office/non-hospital

BILLING INFORMATION

☐ **Bill to insurance** ☐ **Bill to facility**

MUST include copies of the patient's demographics sheet and insurance ID card(s) front and back if not completing the requested information below.

Carrier name _____

Carrier phone _____

Carrier address _____

Policy # _____

Group plan # _____

Name of insured (if other than patient) _____

Date of birth (MM/DD/YYYY) **of insured** _____

Relationship of insured to patient _____

☐ **SECONDARY INSURANCE EXISTS**

If checked, you MUST include secondary insurance information on a separate sheet

PROVIDER INFORMATION

Ordering physician _____

Email results to _____

Phone _____ **Fax** _____

Ordering physician's NPI# _____

Duplicate report sent to _____

Duplicate report fax to _____

CLINICAL HISTORY NARRATIVE/CLINICAL QUESTION

ICD-10 code _____

Specimen collection date (MM/DD/YYYY) _____

Time _____

Distribution: White – UF Path Labs; Yellow – Client Copy
PS159073-6/24/21

SPECIMEN DETAILS *(REQUIRED)*

1. **Specimen source:**
   ☐ Sputum ☐ Body fluid _____
   ☐ BAL ☐ Wound (site) _____
   ☐ Urine ☐ Tissue (site) _____
   ☐ Other (specify) _____
2. **Cystic fibrosis:** ☐ Yes ☐ No
3. **History of mycobacteria:** ☐ Yes (if yes, species _____) ☐ No

Swabs NOT recommended for recovery of AFB organisms

Comments: _____

MICROBIOLOGY TEST REQUEST

Clinical specimen:
☐ **ACID-FAST BACILLI (AFB) SMEAR & CULTURE** with reflex to susceptibility testing

Pure culture of isolate (liquid or solid media)**:**
☐ **ACID-FAST BACILLI (AFB) IDENTIFICATION** with reflex to susceptibility testing

NOTES

If TB is identified, it will be sent to the Florida Department of Health State Laboratory in Jacksonville, Florida, for susceptibility testing.

MIC panel for rapid growers includes: Amikacin, Cefoxitin, Ciprofloxacin, Clarithromycin, Clofazimine, Doxycycline, Imipenem, Linezolid, Moxifloxacin, Tigecycline, Tobramycin and Trimethoprim/Sulfamethoxazole.

MIC panel for slow growers includes:
MAC: Amikacin, Ciprofloxacin, Clarithromycin, Clofazimine, Doxycycline, Linezolid, Moxifloxacin, Rifampin, Rifabutin, and Streptomycin.

Non-MAC: Amikacin, Ciprofloxacin, Clarithromycin, Clofazimine, Doxycycline, Linezolid, Moxifloxacin, Rifampin, Rifabutin and Trimethoprim/Sulfamethoxazole.

TESTING AUTHORIZATION:

I authorize for payment to be made to University of Florida Health Pathology Laboratories for any services furnished by them and also for UF Health to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to these services. If my health insurance plan will not direct payment to UF Health, I agree to forward UF Health all payments received for their services. I also authorize UF Health or any holder of information about me to release to my health insurance plan such information needed to adjudicate their claim.

Patient Signature _____

Date (MM/DD/YYYY) _____

NOTICE TO ORDERING PHYSICIAN:

We respectfully ask that you authenticate your order for the pathologic examination of the accompanying specimen(s) by personally signing this requisition in the space provided or by initialing next to your printed name. If your signature (or initials) are not affixed hereto, you attest that you have caused the subject patient's medical record to include a specific reference (i.e., order) to your intent that the accompanying specimen(s) be examined by a pathologist and that you have personally signed (handwritten or electronic) said reference (i.e., order) in the subject patient's medical record.

Physician's Signature _____

Date (MM/DD/YYYY) _____

Name of person completing form _____