ALBANY MEDICAL CENTER
DEPARTMENT OF
LABORATORY MEDICINE
Molecular Diagnostics
NEW SCOTLAND AVENUE
ALBANY, NEW YORK 12208
PH: (518) 262-3483
FAX: (518) 262-8161

AFFIX ARRIVAL LABEL OR COMPLETE BELOW:

NAME: DOB: SEX:

ADDRESS: MR#:

SS#: PHYSICIAN:

PRIMARY INSURANCE CO.: PLAN NAME:

SUBSCRIBER: RELATIONSHIP TO SUBSCRIBER:

ID# GROUP #:

SECONDARY INSURANCE CO.: PLAN NAME:

RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER: DOB: SEX:

ID# GROUP #:

PHLEBOTOMIST INITIALS	DATE COLLECTED	TIME COLLECTED

PHYSICIAN SIGNATURE: COPY TO:

		DIAGNOSIS / ICD9 CODES MANDATORY FOR EACH TEST ORDERED		
STAT				
PHONE		1.	2.	3.
FAX		4.	5.	6.

NOTIFICATION TO PHYSICIANS AND OTHER PERSONS LEGALLY AUTHORIZED TO ORDER TESTS FOR WHICH MEDICARE REIMBURSEMENT WILL BE SOUGHT:
MEDICARE WILL ONLY PAY FOR TESTS THAT MEET THE MEDICARE COVERAGE CRITERIA AND ARE REASONABLE AND NECESSARY TO TREAT OR DIAGNOSE AN INDIVIDUAL PATIENT. MEDICARE DOES NOT PAY FOR TESTS FOR WHICH DOCUMENTATION, INCLUDING THE MEDICAL RECORD, DOES NOT SUPPORT THAT THE TESTS WERE REASONABLE AND NECESSARY. MEDICARE GENERALLY DOES NOT COVER ROUTINE SCREENING TESTS EVEN IF THE PHYSICIAN OR OTHER AUTHORIZED PRACTITIONER CONSIDERS THE TESTS APPROPRIATE FOR THE PATIENT.

MOLECULAR DIAGNOSTICS

PCR AND NAAT ASSAYS

VIROLOGY

- ☐ CMVD — CYTOMEGALOVIRUS PCR
- ☐ EBVD — EPSTEIN BARR VIRUS PCR
- ☐ ENTVR — ENTEROVIRUS & HPeV PCR
- HERPES SIMPLEX 1 & 2 PCR
  - ☐ HSVD — FROM CSF
  - ☐ HSVDG — FROM SWAB
- ☐ JCVD — JC VIRUS PCR
- ☐ VZVD — VARICELLA PCR

RESPIRATORY VIRUS PCR

- ☐ AMRVR — ADENOVIRUS, METAPNEUMO-VIRUS, & RHINOVIRUS
- ☐ FABRR — FLU A, B & RSV PCR
- ☐ PIVR — PARAINFLUENZA VIRUS PCR
- ☐ FILMRP — RESP. VIRUS PANEL PCR
- ☐ COV19 — SARS2-COV-2 NAAT

BLOOD (WHITE/LAVENDER/YELLOW TOP TUBE)

- ☐ APECNA — ANAPLASMA & EHRLICHIA PCR
- ☐ BABNA — BABESIA MICROTI PCR
- ☐ CMVD — CYTOMEGALOVIRUS PCR
- ☐ CMVDQ — CYTOMEGALOVIRAL LOAD
- ☐ EBVD — EPSTEIN BARR VIRUS PCR
- ☐ EBVDQ — EPSTEIN BARR VIRAL LOAD
- ☐ HCVNA — HEP C RNA PCR
- ☐ HCVQNA — HEP C VIRAL LOAD (QUANT)
- ☐ HCVGT — HEP C GENOTYPING
- ☐ HIVQR — HIV VIRAL LOAD, NAA
- ☐ BKDQ — POLYOMAVIRUS BK QUANT PCR

STOOL PATHOGENS

- ☐ CDIFD — C. DIFFICILE TOXIN PCR
- ☐ EPD — ENTERIC PARASITE PCR PANEL *(Giardia, Cryptosporidium & E.histolytica)*

BACTERIOLOGY

- ☐ BPERD — B. PERTUSIS PCR
- ☐ BSTAD — GROUP A STREP PCR
- ☐ GRPBD — GROUP B STREP PCR
- ☐ LEGD — LEGIONELLA PCR
- ☐ MPAD — MYCOPLASMA PCR
- ☐ MRSAD — MRSA SCREEN BY PCR
- ☐ MSSAD — MSSA/MRSA BY PCR (pre-surgical)
- ☐ URPLD — UREAPLASMA SP., MYCOPLASMA GENTALIUM & HOMINIS

STD TESTING

- ☐ CLLX — CHLAMYDIA TRACHOMATIS, NAAT
- ☐ GCLX — NEISSERIA GONORRHOEAE, NAAT
- ☐ HPVR — HUMAN PAPILOMAVIRUS, NAAT
- ☐ HPVT — HUMAN PAPILOMAVIRUS TYPING
- ☐ TRIKR — TRICHOMONAS, NAAT

SPECIMEN SOURCE_____

OTHER _____
(specify)

TESTING FOR LATENT TB INFECTION

- ☐ LTBI — QUANTIFERON GOLD

GENETIC TESTS BY PCR

- ☐ LEIDN — FACTOR V LEIDEN — LAVENDER TOP TUBE
- ☐ PROTHR — PROTHROMBIN GENE MUTATION — LAVENDER TOP TUBE

I AM THE PHYSICIAN COUNSELING THE PATIENT NAMED ABOVE. I HAVE INFORMED THE PATIENT OF THE NATURE AND LIMITATIONS OF THIS TEST AND HAVE OBTAINED THE PATIENT'S CONSENT FOR THE GENETIC TEST ORDERED ABOVE.

_____

(Signature of physician or other authorized person REQUIRED)