STONE | CLINICAL LABORATORIES

Stone UTI Panel *by PCR*

Information highlighted in GREEN is required

Client Name: ____________________

Account Number: ____________________

Provider: ☐ ____________ ☐ ____________
☐ ____________ ☐ ____________
☐ ____________ ☐ ____________

1. Patient Demographics (attach a copy of patient demographics & insurance info.)

Patient Medical Record Number: ____________

Last Name: ____________ First Name: ____________ D.O.B.: ____________ Gender: ☐ M ☐ F

Patient Street Address: ____________ City: ____________ State: ____ Zip: ____

Bill to: ☐ Medicare ☐ Commercial ☐ Medicaid ☐ Self-Pay ☐ Clint Bill ☐ Other Patient Phone #: ____________

Insurance Co: ____________ Insurance ID#: ____________ Group #: ____________

Insurance Address: ____________ City: ____________ State: ____ Zip: ____

2. Specimen Collection Information

Specimen Collector: ____________ Date Collected: ____________ Time Collected: ____________ AM PM

3. Commonly Used ICD-10 Codes

Check all codes that apply or list all ICD-10 codes in the spaces provided to support the test request(s). Failure to do so may result in delays.

Code	Description	Other
☐ N41.0 -	Acute prostatitis	☐ Other: ________
☐ B37.42 -	Candidal balanitis	☐ Other: ________
☐ B37.3 -	Candidiasis of vulva and vagina	☐ Other: ________
☐ R30.0 -	Dysuria	☐ Other: ________
☐ Z11.2	Encounter for screening for other bacterial diseases	☐ Other: ________
☐ R39.11	Hesitancy of micturition	☐ Other: ________
☐ N41.9 -	Inflammatory disease of prostate, unspecified	☐ Other: ________
☐ N34.1 -	Nonspecific urethritis	☐ Other: ________
☐ N30.81 -	Other cystitis with hematuria	☐ Other: ________
☐ N30.80 -	Other cystitis without hematuria	☐ Other: ________
☐ B37.49 -	Other urogenital candidiasis	☐ Other: ________
☐ Z85.46 -	Personal hx malignant neoplasm, prostate	☐ Other: ________
☐ Z11.8 -	Screen for other infestion / parasitic diseases	☐ Other: ________
☐ R39.16 -	Straining to void	☐ Other: ________
☐ R36.9 -	Urethral discharge, unspecified	☐ Other: ________

4. Organisms Tested

Candida albicans	Klebsiella oxytoca	Pseudomonas aeruginosa
Candida glabrata	Klebsiella pneumoniae	Serratia marescens
Candida parapsilosis	Morganella morganii	Staphylococcus aureus
Candida tropicalis	Mycoplasma hominis	Streptococcus agalactiae
Enterobacter cloacae	Proteus mirabilis	Ureaplasma urealyticum
Enterococcus faecalis	Providence suartii	Staphylococcus saprophyticus
Escherichia coli		

5. Antibiotic Resistance Panel

MecA	KPC	SHV	VanA1	VanB	VIM

6. Additional Tests (Include test name and order code)

☐ Other

Provider Signature Attestation: I am a licensed medical professional. I acknowledge that the test requested herein is medically necessary and the patient is eligible for the test. I attest that the documentation of medical necessity for tests ordered is documented in the patient's medical record, which will be made available upon request of performing laboratory and/or third-party payer. Note: Tests not ordered by the physician who is treating the beneficiary are not reimbursable. Order codes are updated but CPT Codes are not impacted.

Provider's Signature: ____________________ Date: ____________

Internal Use Only: Date: ________ Initials: _____ Shipper Packed Correctly: ___________

*UTI Panel-sterile urine cup & gray top tube