

New Discovery Laboratories | 701 East Pratt Street, Baltimore, MD 21202 | CLIA ID: 21D2196263

PATIENT INFORMATION

| | | | |
|---|----------------------|---|----------------------|
| Patient Name (Last name, First name) | | DOB (mm/dd/yyyy): | |
| <input type="text"/> | | <input type="text"/> | |
| | | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Unknown | |
| Parent/Guardian (if applicable) | | Relationship | |
| <input type="text"/> | | <input type="text"/> | |
| Race: | | Ethnicity: | |
| <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other/Unknown | | <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-hispanic/Latino | |
| Address: | | | |
| <input type="text"/> | | | |
| City: | State: | Zip: | Phone: |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Email: | | SSN: | |
| <input type="text"/> | | <input type="text"/> | |
| Bill to: | | Insurance: | |
| <input type="checkbox"/> Self-Pay <input type="checkbox"/> Facility <input type="checkbox"/> Insurance | | <input type="text"/> | |
| Subscriber ID: | | Group # | |
| <input type="text"/> | | <input type="text"/> | |
| "Specimens cannot be processed without billing information" Provide front and back copies of insurance cards | | | |

PROVIDER INFORMATION

| | | | |
|-----------------------|----------------------|----------------------|----------------------|
| Client Name / Account | | | |
| <input type="text"/> | | | |
| Address: | | | Suite# |
| <input type="text"/> | | | <input type="text"/> |
| City: | State: | Zip: | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Phone: | Fax # | | |
| <input type="text"/> | <input type="text"/> | | |
| Provider's NPI# | Ordering Provider: | Collection Date: | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Collector's Name: | | | Collection Time: |
| <input type="text"/> | | | <input type="text"/> |

| | | | |
|-------------------|--|---|---|
| TEST NAMES | <input type="checkbox"/> UTI w/ ABX resistance genes | <input type="checkbox"/> UTI PLUS w/ ABX resistance genes | <input type="checkbox"/> Wound/Derm w/ ABX resistance genes |
| | <input type="checkbox"/> STI | <input type="checkbox"/> Vaginitis | <input type="checkbox"/> COVID-19 |

MEDICAL NECESSITY

At the government's request, New Discovery Laboratories would like to remind all physicians that when ordering tests expected to be paid under federal health care programs, such as Medicare and Medicaid, the tests must meet the following conditions:

- (1) included as covered services,
- (2) reasonable,
- (3) medically necessary for the treatment and diagnosis of the patient and
- (4) not for screening purposes.

 Provider Signature:

PATIENT ACKNOWLEDGMENT

The information I have provided on this form is accurate. I authorize New Discovery Labs to release the results of this test to my treating physician or facility. I hereby authorize my insurance or other payment to New Discovery Labs for services I receive. I am aware that New Discovery Labs may be an out-of-network provider with my insurer. I am aware that I am responsible for all co-pays and deductibles not covered by insurance or other payers.

 Patient Signature:

 Date:

Patient Name:

DOB:

Collection Date:

Input fields for Patient Name, DOB, and Collection Date.

PANEL LIST

Main diagnostic panel containing sections for UTI w/ ABX Resistance, UTI PLUS w/ ABX Resistance, Wound/Derm w/ ABX Resistance, Vaginitis, and STI. Each section lists organisms, antibiotic-resistance genes, ICD-10 codes, and specimen sources.

ANTIBIOTICS INFORMATION

HAS YOUR PATIENT TAKEN ANTIBIOTICS IN THE PAST 72 HOURS? Yes No