FRY LABORATORIES, L.L.C. - *Requisition* (international)

14807 N. 73rd Street, Suite 103 Scottsdale, AZ 85260
(866)927-8075 phone (480)656-4932 fax frylabs.com CLIA#03D1026968

____/____/____
LAB BILL NP

LAB USE ONLY

v03.27.2019i

HEALTHCARE PROVIDER INFORMATION (*Signature is required*)

Physician Name: _____ NPI#: _____

Facility / Address: _____

City: _____ State/Prov: _____ Zip: _____ Phone: (____)_____ Fax: (____)_____

PHYSICIAN INFORMED CONSENT ATTESTATION (*Healthcare Provider Signature Required*)

I, the listed ordering healthcare provider, confirm that this test is medically necessary for the diagnosis or detection of a disease, infection, illness, impairment, symptom, syndrome, or disorder. These results will be used as part of the medical management and treatment decisions for the patient. I will provide appropriate ICD-10 diagnosis codes to support testing. I confirm that I am authorized by law to order the test(s) requested herein. I am aware that DNA sequencing may detect organisms of unknown clinical significance and that results are the closest known match. I understand that test requests without this section completed will not be processed.

Healthcare Provider Signature: _____ **Date:** ____/____/_____

PATIENT INFORMATION (*Signature is required*)

Last Name: _____ First Name: _____

Mailing Address: _____ Phone: (____)_____ DOB: ____/____/_____

City: _____ State: _____ Zip: _____ Gender: ◯male ◯female Email: _____

Patient or Guardian Signature: _____ **Date:** ____/____/_____

PAYMENT INFORMATION (*Select a payment method and signature is required*)

Payment Type: ◯VISA ◯MasterCard ◯Discover ◯American Express ◯Check #_____

Card Number: _____ Name On Card: _____

Card Holder Signature: _____ Expiration: ____/_____ Security Code: _____ Zip: _____

Option 1: PATIENT SELF-PAYMENT (*Provide payment information*)

I, the listed patient, choose to provide payment for the requested tests when they are received. I understand that failure to provide pre-payment for the requested services, in full, may result in delays of the test results. I have completed the Payment Information Section.

TEST ORDER AND SAMPLE INFORMATION (*ICD-10 Codes and Collection Date are required*)

Dx ICD-10 Codes: _____ _____ _____ Collection Date: _____/_____/_____ Time: _____

Sequencing Tests / Panels (complete sample type) — A

- ◯ Pan-Bacterial (Bacteria/Archaea) DNA Analysis
- ◯ Pan-Eukaryotic (Protozoa/Fungi) DNA Analysis
- ◯ Pan-Eukaryotic DNA Analysis + Mosaic Stain

Sample Type (select sample type)

- ◯ Blood Sample (submit lavender)
- ◯ Stool Sample (submit stool kit)
- ◯ Fluid Sample (CSF, Joint, Sputum) (submit red top)
- ◯ Tissue Sample (submit tissue kit)
- ◯ Other: _____ (contact lab)

◯ Stained Blood Film Test (submit lavender) — B

Modified May-Grünwald & Giemsa Stains

◯ Advanced Stain Test (submit lavender) — C

Fluorescent DNA Stain

◯ Mosaic Fungi Stain Test (submit lavender) — M

Fluorescent Fungi and DNA Stain

◯ Complete Stain Profile (submit lavender) — D

Modified May-Grünwald & Giemsa Stains
Fluorescent DNA Stain

◯ Mosaic Fungi Stain Profile (submit lavender) — E

Modified May-Grünwald & Giemsa Stains
Fluorescent Fungi and DNA Stain

◯ Complete Serology Profile (submit tiger) — F

Anaplasma phagocytophilum IFA IgM/IgG
Babesia microti IFA IgM/IgG
Bartonella quint./hens. IFA IgM/IgG
Ehrlichia chaffeensis IFA IgM/IgG
Lyme Line Blot IgM/IgG
Q-Fever (Coxiella burnetii) IFA IgM/IgG
Rickettsia rickettsii/typhi IFA IgM/IgG
Toxoplasma gondii IFA IgM/IgG

◯ Co-Infection + Profile (submit lav & tiger) — G

Anaplasma phagocytophilum IFA IgM/IgG
Babesia microti IFA IgM/IgG
Bartonella quint./hens. IFA IgM/IgG
Ehrlichia chaffeensis IFA IgM/IgG
Lyme Line Blot IgM/IgG
Q-Fever (Coxiella burnetii) IFA IgM/IgG
Rickettsia rickettsii/typhi IFA IgM/IgG
Toxoplasma gondii IFA IgM/IgG
Modified May-Grünwald & Giemsa Stains
Fluorescent DNA Stain

LAB USE ONLY

Some tests use components that are for Research Use Only. Please visit our website for more information about each assay.