



For Lab Use Only	Facility Name	Ordering Physician Name Last First
	Address	Physician NPI No.
	City, State, Zip	Physician Phone No. ()
	Facility Phone Number ()	Report Fax Number ()

Patient Name (Last) (First)	Insurance Info: Attach a copy of front & back of Insurance card or face sheet <input type="checkbox"/> Private Ins/PPO <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Patient <input type="checkbox"/> Client
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Client Acct # Unique ID or MRN	DOB-Required	Sex M F	Responsible Party (Please Print)
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Patient's Phone Number ()	Collection Date & Time	Collection by-Required	Address
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Copy to: First Name Last Name	City, State, Zip
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Copy to complete address for mailing:	ICD9 Code(s) - REQUIRED INFORMATION
	Physician Signature: Date:

Each individual test and CMS approved panel must have ICD-9 code(s) to indicate the medical necessity of the test requested. Please provide all applicable ICD-9 codes for the tests ordered. @ Tests for Medicare Patients Must be screened to determine if an Advanced Beneficiary Notice (ABN) is required. An ABN must be provided to the Medicare patient if there is a reason to believe Medicare will deny the test. Medicare may deny tests due to frequency. Medicare does not generally cover routine screening tests.

Sample Type

Plasma Serum Urine Paraffin Block; site _____
 Viral Transport Media Other; type _____ Type _____ Block No. _____

Return block to address above or address:

Genotyping and Antiviral Resistance Testing

	Test Code	Specimen
<input type="checkbox"/> Hepatitis C Virus (HCV) Genotype, Serum	HCVGEN	Ø
<input type="checkbox"/> HIV-1 Antiviral Resistance Testing - Integrase, Plasma	AVIN	*
<input type="checkbox"/> HIV-1 Antiviral Resistance Testing - RT and Protease, Plasma	AVRT	*
<input type="checkbox"/> HPV 16/18 Typing	HPVPCR	PET, LP
<input type="checkbox"/> HPV 6/11 Typing	HPV6PC	PET
<input type="checkbox"/> HPV DNA Probe High Risk Reflex to 16/18 Typing	HPVHRT	LP

Viral Load

	Test Code	Specimen
<input type="checkbox"/> Adenovirus DNA, Quantitative PCR, Plasma	ADVQT	*
<input type="checkbox"/> BK Virus DNA, Quantitative PCR, Plasma	BKVPC	*
<input type="checkbox"/> BK Virus DNA, Quantitative PCR, Urine, Sterile Container	BKVPCU	U
<input type="checkbox"/> Cytomegalovirus (CMV) DNA, Quantitative PCR, Plasma	CMVQT	▲
<input type="checkbox"/> Epstein-Barr Virus (EBV) DNA, Quantitative PCR, Plasma	EBVQP	***
<input type="checkbox"/> Hepatitis B Virus (HBV) DNA, Quantitative PCR, Serum	HBPCR	Ø
<input type="checkbox"/> Hepatitis C Virus (HCV) RNA, Quantitative PCR, Serum	HCVPCR	Ø
<input type="checkbox"/> HIV-1 RNA, Quantitative PCR, Plasma@	HIVPCR	***
<input type="checkbox"/> Human Herpes Virus -6 (HHV-6) DNA Quantitative PCR, Plasma	HHV6QT	*

Qualitative Nucleic Acid Tests

	Test Code	Specimen
<input type="checkbox"/> Cytomegalovirus (CMV) DNA, Qualitative PCR, Non-Plasma	CMVQL	BAL, T, U, PET
<input type="checkbox"/> Herpes Simplex Virus (HSV) & Varicella Zoster Virus (VZV), Qualitative PCR, Lesions	HSVZL	VTM
<input type="checkbox"/> Influenza A PCR w/Reflex to 2009 H1N1 Subtyping and Oseltamivir Resistance	FLUAPX	NP, BAL
<input type="checkbox"/> Respiratory Syncytial Virus (RSV) & Human Metapneumovirus (hMPV) RNA, Qualitative PCR	RMPCR	NP, BAL

Specimen Type	Consult Lab Guide for Specimen Handling at www.stanfordlab.com or call Customer Service at 1 (877) 717-3733
∅	- 3 mL Serum Gold-Top/SST tube, centrifuge within 6 hours of collection. Transport refrigerated. If transport is greater than 2 days, centrifuge and transfer serum to a screw-capped tube and transport specimen frozen.
*	- 3 mL EDTA or ACD Plasma, centrifuge within 6 hours of collection and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
PET	- 3 to 5 paraffin-embedded tissue scrolls at 5-10 µm thickness in a screw cap tube. Transport at room temperature.
LP	- 1-6 mL SurePath™ Liquid Based Pap. Transport at room temperature.
U	- 2 mL Urine, transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
▲	- 3 mL ACD Plasma, centrifuge within 6 hours of collection and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
***	- 3 mL EDTA Plasma, centrifuge within 6 hours of collection and transfer plasma to a screw-capped tube. Transport refrigerated. If transport is greater than 2 days, transport specimen frozen.
NP	- 1 nasopharyngeal (NP) flocked swab in Viral Transport Media (4MRT). Transport refrigerated. If transport is greater than 2 days, transport frozen.
VTM	- 1 flocked or Dacron swab in Viral Transport Media (4MRT). Transport refrigerated. If transport is greater than 2 days, transport frozen.
BAL	- 4-12 mL Bronchoalveolar lavage (BAL) fluid in a sterile container. Transport refrigerated. If transport is greater than 2 days, transport frozen.
T	- 5 mm ³ tissue, transport refrigerated.

**PANELS AND PROFILES ARE FOR ORDERING CONVENIENCE ONLY.
ALL TESTS MAY BE ORDERED SEPARATELY.**

Respiratory Syncytial Virus (RSV) and Human Metapneumovirus (hMPV) RNA, Qualitative PCR Test Code: RMPCR

Human Metapneumovirus (hMPV) RNA, Qualitative PCR
Respiratory Syncytial Virus (RSV) RNA, Qualitative PCR

MPVPCR
RSVPCR

Ship to:

Stanford's Anatomic Pathology and Clinical Laboratory

Attn: Specimen Processing

3375 Hillview Ave

Palo Alto, CA 94304

Phone: 1 (877) 717-3733

If shipping Friday check for Saturday delivery

Shipper's Responsibility: The shipper is required to comply with the rules and guidelines for transport of medical specimens as set forth by the United States government, the government of the country of origin and international regulatory agencies. Failure to follow instructions for packaging and shipping specimens can result in the delay, loss or destruction of your specimens. Stanford University Medical Center Clinical Laboratories will not be held responsible for any liability attributable to the shipper's improper actions or failure to comply with regulations.

Patient's First Name: _____

Patient's Last Name: _____

Patient's MRN: _____

Or Affix Label Here



STANFORD
UNIVERSITY
MEDICAL CENTER
Clinical Laboratories
3375 Hillview Avenue
Palo Alto, CA 94304
(877) 717-3733

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the **D.** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not responsible for payment, and I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.