1500 Interstate 35W Denton, TX 76207 **Customer Service:** 866-287-3218

Web: HealthTrackRx.com

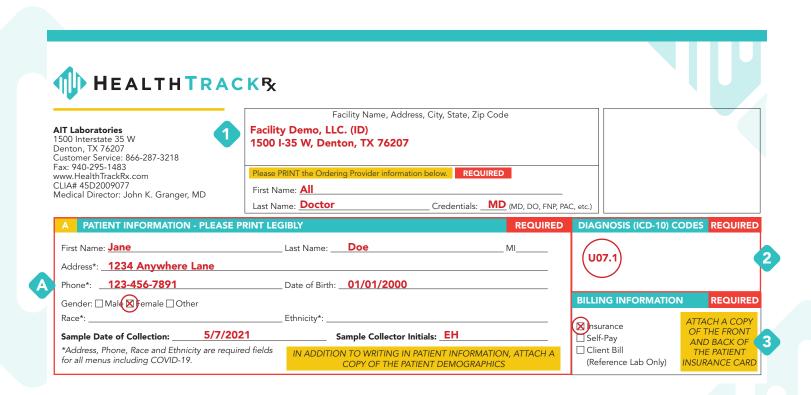
INSTRUCTIONS FOR COMPLETING A HEALTHTRACKRX REQUISITION

If you have any questions, please contact your Account Representative, or call HealthTrackRx Client Experience at 866-287-3218.

Section 1



- 1 Facility Name (required)
 - Clearly print facility name, full address, ordering provider's name and credentials.
- 2 Diagnosis (ICD-10) Codes (required)
 - Provide all applicable ICD-10 codes to the highest degree of specificity.
- 3 Billing Information (required)
 - Mark insurance, self-pay or client bill (reference lab only). If marking insurance, attach a copy of the patient demographics (face sheet) and insurance provider information.
- A Patient Information (required)
 - Clearly print the patient's legal first and last name, full patient address, date of birth and gender. Ensure date of collection and sample collector initials are provided.





Section 2

B Infectious Disease Test Orders (required)

Select either primary menu or specific pathogens within the menu. Testing will be delayed if an order is not selected. Select sample type submitted for testing.

B INFECTIONS DISEASE TEST ORDERS (Select either primary menu or pathog	gens within the menu) SELECT ONE OR MORE (REQUIRED)
SAMPLE TYPE: Vaginal Swab Penile Swab Urine Swab Other: SEXUALLY TRANSMITTED INFECTION** Atopobium vaginae 68, 69, 70, 73, 82 Chlamydia trachomatis	AMPLE TYPE: X aginal Swab Penile Swab Urine Swab Other: CHLAMYDIA, GONORRHEA & TRICHOMONAS** Chlamydia trachomatis Neisseria gonorrhoeae
□ Gardnerella vaginalis □ Neisseria gonorrhoeae □ Hrichomonas vaginalis □ Trichomonas vaginalis □ Trichomonas vaginalis □ High Risk HPV Types 16, 18, 26, 31, 33, □ Ureaplasma urealyticum, parvum 35, 39, 45, 51, 52, 53, 56, 58, 59, 66, 67, □ Antibiotic Resistance Genes (listed below)	☐ Trichomonas vaginalis
SAMPLE TYPE: Vaginal Swab Other:	SAMPLE TYPE: Vaginal Swab Other:
BACTERIAL VAGINOSIS**	AEROBIC VAGINITIS**
□ Atopobium vaginae □ Megasphaera (type 1 and 2) □ Mycoplasma genitalium, hominis □ MyAB 2, 3 (bacterial vaginosis associated □ Darablasma urealyticum, parvum □ Dardnerella vaginalis □ Antibiotic Resistance Genes (listed below)	□ Enterococcus faecalis, faecium □ Escherichia coli □ Staphylococcus aureus □ Streptococcus agalactiae? □ Antibiotic Resistance Genes (listed below)

Section 3



C Patient Acknowledgment (required)

A patient signature is required.

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Authorized Healthcare Provider Acknowledgment (required)

A healthcare provider signature is required.

C PATIENT ACKNOWLEDGMENT		REQUIRED
This specimen was provided voluntarily for analysis and I authorize AIT Laborator I agree to the declarations and terms in the patient acknowledgment and irrevoc		
Iona Daa	Date: 5/8/2021	
Patient Signature: Jane Doe	Date:Date:	
Patient Signature: Jane Doe AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGME		REQUIRED
	ENT ered is recorded in the patient's chart. I have certified medical necessity in	Section C and/or I have provided the