FutureGeneration Laboratories
10211 Pacific Mesa Blvd, Suite 408
San Diego, CA 92121
Ph: 619-419-0229 Fax: 619-505-9106
CLIA# 05D2256278

LABORATORY TEST REQUISITION / AUTHORIZATION

Patient Information			Provider Information		
Name (Last, First, MI)			Facility/Clinic/Location		
Date of Birth	MRN/ID Number		Ordering Physician		
Phone Number			Phone Number		
Email			NPI		
Mailing Address			Facility Address		
City	State	Zip Code	City	State	Zip Code

Additional Required Information			
Gender ☐ Male ☐ Female ☐ Non-Binary	Pregnant? ☐ Yes ☐ No ☐ N/A	Ethnicity ☐ Hispanic/Latino ☐ Non Hispanic/Latino	Race ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ American Indian/Alaskan
Insurance Provider Please Attach a copy of the patient's insurance card	Policy Number		Diagnosis/Clinical Information

The Physician or alternate contact completing this form confirms that they are compliant to the HIPAA Privacy Rule (45 CFR Parts 160 and 164) and that the fax number listed is a secure line to send test results.

Test Requested

Collection Date and Time: **Collected by:** ☐ Clinician ☐ Patient

Test	CPT	ICD-10 Code	Specimen Source
☐ Chlamydia/Gonoccocus, NAA	87491	☐ Z11.3 ☐ Z11.8 ☐ _____	☐ Vaginal ☐ Rectal ☐Urine ☐ OP
☐ Bacterial Vaginosis, NAA	87798	☐ Z11.2 ☐ N76.0 ☐ _____	☐ Vaginal
☐ CV/TV, NAA *Candida* species grp, *C. glabrata, T. vaginalis*	87801 87661	☐ Z11.3 ☐ Z11.8 ☐ _____	☐ Vaginal
☐ Flu A/B/RSV, RT-PCR RSV: Respiratory syncytial virus	87801	☐ Z11.59 ☐ J10.1 ☐ _____	☐ Nasopharyngeal
☐ Parainfluenza Virus, RT-PCR	87631	☐ Z11.59 ☐ J12.2 ☐ _____	☐ Nasopharyngeal
☐ AdV/hMPV/RV, RT-PCR Adenovirus,human metapneumovirus, rhinovirus	87798	☐ Z11.59 ☐ B97 ☐ _____	☐ Nasopharyngeal
☐ COVID-19 Antigen	98911	☐ _____	☐ Nasal

IMPORTANT: SPECIMENS MUST HAVE THE PATIENT'S NAME, DATE OF BIRTH, COLLECTION DATE AND TIME

*The SARS-CoV-2 assay is for use only under Emergency Use Authorization (EUA) in the US laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. §263a, to perform high complexity tests.

PATIENT CONSENT: I, the undersigned, have been informed and have been given the opportunity to ask questions about the test purpose, procedures, possible risks and benefits, and I understand that I am responsible for the cost of services rendered if insurance does not cover the costs.

X	
Patient / Parent / Guardian Signature	Date

FutureGeneration Laboratories
10211 Pacific Mesa Blvd, Suite 408
San Diego, CA 92121
Ph: 619-419-0229 Fax: 619-505-9106
CLIA# 05D2256278

INFECTIOUS DISEASE REQUISITION

Patient Information	
*Name (Last, First)	*Date of Birth

Clinical Questions	
☐ Yes ☐ No	Are you full vaccinated against COVID-19? (You are considered fully vaccinated 2 weeks after your second dose in a two-shot series like Pfizer-BioNTech or Moderna vaccines, or 2 weeks after a single-dose vaccine such bas J&J Janssen vaccine).
☐ Yes ☐ No	In the last two weeks, have you been in contact with someone who has COVID-19?
☐ Yes ☐ No	In the last 10 days, have you experienced symptoms of fever, cough, difficulty breathing, sore throat, muscle aches or body aches, headache, new loss of taste or smell, diarrhea, congestion or runny nose, nausea or vomiting?

Screening Consent

1. I authorize testing as ordered by an authorized medical provider or public health official (i.e. COVID-19, through a nasal, nasopharyngeal, or oropharyngeal swab).
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I acknowledge that a positive test result (i.e. positive COVID-19, influenza virus) is an indication that I must self-isolate and/or wear a mask or face covering as directed, in an effort to avoid infecting others.
4. I understand that the medical provider who performed the screening is not acting as my primary medical provider, this testing does not replace treatment by my primary medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree that I will seek medical advice, care, and treatment form my primary medical provider if I have questions or concerns, or if my condition worsens.
5. I understand that the specific medical provider who performed the screening and her employer or legal entity which she represents or has an ownership interest in, cannot be held responsible for any inaccurate test result that may be generated by the screening or testing procedures. I understand that in signing this consent form, I am agreeing to hold the medical provider and any employer or entity for which he/she has an ownership interest free and harmless from potential liabilities. This means that I cannot sue the medical provider or his/her employer or any entity in which he/she has an ownership interest if the test result is not accurate.

   I, the undersigned, have been informed about the test purpose, procedures, possible benefits, and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing.

X	
Patient / Parent / Guardian Signature	Date

The Infectious Disease Requisition is based upon current guidance for exposure risk management from the Center for Disease Control and Public Health Agencies. All patients are therefore urged to follow the guidance from cdc.gov and local county department of health.