RPP – REQUISITION FORM
(Respiratory Pathogen Panel)

SUREDx
a division of Suretox laboratory

Practice Information

1. PATIENT INFORMATION

Last Name _____

First Name _____

MI _____

Sex: ☐ F ☐M DOB __/__/____ Resides: ☐Home ☐Facility

Name of Facility: ☐N/A _____

Address: _____

City, State, ZIP: _____

Facility Contact Person: _____

Facility Contact Phone: _____

2. PAYMENT INFORMATION

BILL: ☐ Patient ☐ Insurance ☐ Other

☐See attached copy of patient demographics/insurance info

Primary Insured Name:

Relationship to insured: ☐Self ☐Spouse ☐Child ☐ Other

Insurance Company: _____

Member ID# _____ Group ID# _____

City, State, ZIP: _____

☐No Fault, Workers Comp Claim # _____

Adjuster Name: _____ Phone# _____

Date of Injury __/__/____ Body Part: _____

3. SPECIMEN COLLECTION

Date of Collection: _____ Time: _____ ☐AM ☐PM

Collected by: _____

TYPE: RPP (Swab) ☐ Oropharyngeal swab ☐ Nasopharyngeal swab

4. Targets

Viral Targets

- Adenovirus
- Coronavirus NL63
- Coronavirus 229E
- Coronavirus OC43
- Human metapneumovirus
- Rhinovirus
- Enterovirus
- Influenza A/H1-2009
- Influenza A/H3
- Influenza B
- Parainfluenza 1
- Parainfluenza 2
- Parainfluenza 3
- Parainfluenza 4
- Respiratory Syncytial Virus A
- Respiratory Syncytial Virus B
- Epstein-Barr virus (EBV)
- Cytomegalovirus
- Human herpesvirus 6 (HHV-6)
- Varicella zoster virus (VZV)

Bacterial Targets

- Chlamydophila pneumoniae
- Mycoplasma pneumoniae
- Streptococcus pneumoniae
- Klebsiella pneumoniae
- Legionella pneumophila
- Haemophilus influenzae
- Bordetella pertussis

5. ICD – 10 Codes

- ☐ Z03.818 possible exposure to COVID 19
- ☐ Z20.828 actual exposure COVID 19
- ☐ B99.9 Unspecified Infectious Disease
- ☐ J06.9 Acute Upper Respiratory, Unspecified
- ☐ J00 Acute Nasopharyngitis
- ☐ J22 Acute Lower Respiratory
- ☐ J01.90 Acute Sinusitis, Unspecified
- ☐ J98.9 Respiratory Disorder, Unspecified
- ☐ J02.9 Acute Pharyngitis, Unspecified
- ☐ R05 Cough
- ☐ R50.9 Fever, unspecified
- ☐ Z57.9 Occupational exposure to unspecified risk factor

6. RESULTS

RESULTS SENT TO: (SELECT ALL THAT APPLY)

☐Phvsicians Portal ☐ Fax

7. PATIENT AUTHORISATION

I authorize Suretox to release the results of this testing to the treating authorized health care provider or facility. I hereby authorize my insurance benefits to be paid directly to Suretox for services I received. I understand that Suretox may be an out-of-network provider with my insurer. I also understand that in sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit to Suretox immediately. Failure to send payment with 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau.

Patient Signature: _____ Date: _____

8. PHYSICIAN SIGNATURE

I authorize the above ordered test(s)

Provider Signature: _____

Date: _____

Pt.Name _____

Date_____DOB_____

BAR CODE/////////

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