



FAX To: 303-274-4598

Full Spectrum Screening/Biological and Environmental

NPI# 1316267164

CLIA# 45D1051736

REQUISITION FORM

CLIA# 24D040292

AIHA# 163230

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|-------------------------------------|------------------------|--------------|--|--------------------------|---------------------|-------|--|--------------------------|--------------------|--|--|--------------------------|--------------------------------|--|--|--------------------------|----------------|--|--|-------------------------------------|-----------|--------------|--|--------------------------|--------------------|-----------|---------------------|--------------------------|-------------------|-----------|---------------------|--------------------------|---------------|-----------|---------------------|--------------------------|-------------------|-----------|---------------------|--------------------------|----------------|-----------|---------------------|--------------------------|----------------------|-----------|---------------------|--------------------------|----------------------|--|--|-------------------------------------|-------------------------|--------------------|--|--------------------------|--------------------------|--|--|--------------------------|----------------|--------------------------------------|--|--------------------------|--------------------|--|--|--------------------------|--|--|--|--------------------------|---------------|--|--|--------------------------|-----------------------------------|--|--|--------------------------|--|--|--|--------------------------|------------|--|--|
| Patient's Information <small>(please fill in ALL italicized/red areas)</small> | | Physician's Information <small>(please fill in ALL italicized/red areas)</small> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Name (first):</i> _____ <small>(middle initial):</small> _____ | | <i>Dr.'s Name:</i> _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Name (last):</i> _____ | | <i>Dr.'s Signature:</i> _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address; Street: _____ City: _____ Zip: _____ | | Diag. Code: _____ CPT(optional): _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Phone#:</i> _____ | | Dr.'s NPI#: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient's Date of Birth: ___/___/___ M F Relationship to Insured: self spouse child other | | <i>Practice Name:</i> _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Ins. ID #: _____ | | <i>Street Address:</i> _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Group #: (FECA) _____ | | <i>City:</i> _____ <i>Zip:</i> _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ins. Plan Name/Program Name: Or policy#: _____ | | <i>Phone:</i> _____ <i>Fax:</i> _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insured's: Name: _____ Ins. ID#: _____ Address; Street: _____ City: _____ Zip: _____ Phone#: _____ Date of Birth: ___/___/___ M F Employer: _____ Other Insured's: Name: _____ Address: (if different from primary insured) Street: _____ City: _____ Zip: _____ Date of Birth: ___/___/___ M F Policy/Group#: _____ Plan name/Program name: _____ | | <p>Tests requested: please put an <input checked="" type="checkbox"/> in the box to the left of the test requested. You may request Full package tests, or individual selections below the full package tests.</p> <table border="1"> <tr> <td><input checked="" type="checkbox"/></td> <td>Full Mycotoxin Package</td> <td>Urine</td> <td>(Or <input type="checkbox"/> single tests below)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Trichothecene Group</td> <td>ELISA</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Ochratoxin Group A</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Aflatoxin Group B1, B2, G1, G2</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>DSMA Challenge</td> <td></td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Mycotoxin</td> <td>Blood</td> <td>DNA Probes only for Hospitalized patients</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Stachybotrys Panel</td> <td>DNA Probe</td> <td>(hospitalized only)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Aspergillus Panel</td> <td>DNA Probe</td> <td>(hospitalized only)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Candida Panel</td> <td>DNA Probe</td> <td>(hospitalized only)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Penicillium Panel</td> <td>DNA Probe</td> <td>(hospitalized only)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Fusarium Panel</td> <td>DNA Probe</td> <td>(hospitalized only)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Histoplasmosis Panel</td> <td>DNA Probe</td> <td>(hospitalized only)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Lyme's Disease Panel</td> <td></td> <td></td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Full Environmental Pack</td> <td>Residential</td> <td>(Or <input type="checkbox"/> single tests below)</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Indoor Air Quality (IAQ)</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Allergens(ACA)</td> <td>Dog, cat, cockroach 1, dust mite 1&2</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Water Quality (WQ)</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Live Plant Allergens And PEST Ids. (LPAPI)</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Lead/Asbestos</td> <td><input type="checkbox"/> (circle which test, or put <input checked="" type="checkbox"/> in box for both)</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Foreign Gasses Substances (FGS)**</td> <td>(Or <input type="checkbox"/> in box for all)</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td colspan="3">Remediation Services REQUIRED, Patient's health compromised *****</td> </tr> <tr> <td><input type="checkbox"/></td> <td>Remediate:</td> <td></td> <td></td> </tr> </table> | | <input checked="" type="checkbox"/> | Full Mycotoxin Package | Urine | (Or <input type="checkbox"/> single tests below) | <input type="checkbox"/> | Trichothecene Group | ELISA | | <input type="checkbox"/> | Ochratoxin Group A | | | <input type="checkbox"/> | Aflatoxin Group B1, B2, G1, G2 | | | <input type="checkbox"/> | DSMA Challenge | | | <input checked="" type="checkbox"/> | Mycotoxin | Blood | DNA Probes only for Hospitalized patients | <input type="checkbox"/> | Stachybotrys Panel | DNA Probe | (hospitalized only) | <input type="checkbox"/> | Aspergillus Panel | DNA Probe | (hospitalized only) | <input type="checkbox"/> | Candida Panel | DNA Probe | (hospitalized only) | <input type="checkbox"/> | Penicillium Panel | DNA Probe | (hospitalized only) | <input type="checkbox"/> | Fusarium Panel | DNA Probe | (hospitalized only) | <input type="checkbox"/> | Histoplasmosis Panel | DNA Probe | (hospitalized only) | <input type="checkbox"/> | Lyme's Disease Panel | | | <input checked="" type="checkbox"/> | Full Environmental Pack | Residential | (Or <input type="checkbox"/> single tests below) | <input type="checkbox"/> | Indoor Air Quality (IAQ) | | | <input type="checkbox"/> | Allergens(ACA) | Dog, cat, cockroach 1, dust mite 1&2 | | <input type="checkbox"/> | Water Quality (WQ) | | | <input type="checkbox"/> | Live Plant Allergens And PEST Ids. (LPAPI) | | | <input type="checkbox"/> | Lead/Asbestos | <input type="checkbox"/> (circle which test, or put <input checked="" type="checkbox"/> in box for both) | | <input type="checkbox"/> | Foreign Gasses Substances (FGS)** | (Or <input type="checkbox"/> in box for all) | | <input type="checkbox"/> | Remediation Services REQUIRED, Patient's health compromised ***** | | | <input type="checkbox"/> | Remediate: | | |
| <input checked="" type="checkbox"/> | Full Mycotoxin Package | Urine | (Or <input type="checkbox"/> single tests below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Trichothecene Group | ELISA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Ochratoxin Group A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Aflatoxin Group B1, B2, G1, G2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | DSMA Challenge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input checked="" type="checkbox"/> | Mycotoxin | Blood | DNA Probes only for Hospitalized patients | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Stachybotrys Panel | DNA Probe | (hospitalized only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Aspergillus Panel | DNA Probe | (hospitalized only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Candida Panel | DNA Probe | (hospitalized only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Penicillium Panel | DNA Probe | (hospitalized only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Fusarium Panel | DNA Probe | (hospitalized only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Histoplasmosis Panel | DNA Probe | (hospitalized only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Lyme's Disease Panel | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input checked="" type="checkbox"/> | Full Environmental Pack | Residential | (Or <input type="checkbox"/> single tests below) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Indoor Air Quality (IAQ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Allergens(ACA) | Dog, cat, cockroach 1, dust mite 1&2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Water Quality (WQ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Live Plant Allergens And PEST Ids. (LPAPI) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Lead/Asbestos | <input type="checkbox"/> (circle which test, or put <input checked="" type="checkbox"/> in box for both) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Foreign Gasses Substances (FGS)** | (Or <input type="checkbox"/> in box for all) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Remediation Services REQUIRED, Patient's health compromised ***** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Remediate: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Please write in remediation service prescribed...

**Foreign Gasses: Radon, Formaldehyde, Carbon Dioxide, Carbon Monoxide, Hydrogen Sulfide, Oxygen, Combustible Gasses.

Circle the above item(s) you want tested. Separate charges apply for each selected item.